UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION
Case 01-4319-CIV-KING

SYLVIA ALLEN
Plaintiff,
vs.
R.J REYNOLDS TOBACCO COMPANY,
and PHILIP MORRIS INCORPORATED
Defendants.

MIAMI, FLORIDA
FEBRUARY 11, 2003
TUESDAY - 1:45 P.M.
AFTERNOON SESSION

TRANSCRIPT OF JURY TRIAL PROCEEDINGS
BEFORE THE HONORABLE JAMES LAWRENCE KING,
UNITED STATES DISTRICT JUDGE

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AFTERNOON SESSION

THE COURT: Are we ready to proceed, gentlemen?

MR. YAFFA: Yes, Your Honor, we are.

MR. REID: Your Honor, we just want to reiterate our objection to this witness giving opinions as to what the cell type was.

THE COURT: We will have to see what the question is and then you can make your objection.

For example, if he says "Tell us what you think of Dr. Jones' summary? Is Dr. Jones a great doctor, wonderful doctor, lousy doctor?" we are going to sustain it.

If he says "Did you interpret this from treating your patient?" it will probably go in.

MR. REID: Our ground was he wasn't disclosed to give expert opinion, and there was no disclosure with regard to this witness.

THE COURT: That was required in the pretrial stipulation, is that it?

What is your response to the fact they were not told he would be an expert?

MR. YAFFA: Your Honor, he is a treating physician. He would come in and testify about what he did, the diagnosis he reached and the care he gave.

THE COURT: I think that fits within your parameters

about your entitlement to have your objections sustained.

If he starts to opine on somebody else's field or thoughts, if he said "I sent this patient out to five other doctors and they wrote back, and whatever they wrote back is," if it's in evidence, he can say "Yes, I relied on it. I did this. I did that."

But if he starts to get into whether or not Dr. Somebody Else, Dr. X's opinion that the cancer traveled from the lungs to the leg, whether he believes that or doesn't believe it, I am going to sustain it.

This is all anticipatory rulings. Usually I find out so much of this stuff you all worry about in advance, when you get around to asking the question, it is simply not a problem at that point, but we will see. We will see.

Bring in the jury.

MR. YAFFA: May I get the doctor, Your Honor?

THE COURT: Yes, please.

The one juror has asked if we are going to be in session next Monday, which is a holiday, and, if not, the juror

wants to make a doctor's appointment, Vickie -- is that it -- but will not make it if we are going to be in session?
I presume we are not. Is that correct?
MR. REILLY: As far as I know, Your Honor, we are not.
MR. COHEN: I would think we are on holiday, too.
MR. COHEN: Yes, sir.

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[The jury enters the courtroom at 1:48 p.m.]
THE COURT: Thank you. Be seated.
Ladies and gentlemen, one of you inquired as to whether or not we would be taking next Monday, a Federal holiday, whether we would there in trying the case or we would be taking a day off.
The answer is we will be taking the day off. We will not be in trial. Those of you who would like to make plans of your own for that day will be free to do so.
Mr. Yaffa.
MR. YAFFA: Thank you, Your Honor.
The plaintiffs at this time will call Dr. Thomas Temple to the stand.
THE DEPUTY CLERK: Would you raise your right hand, please?
HARRY THOMAS TEMPLE, PLAINTIFF'S WITNESS, SWORN.
THE DEPUTY CLERK: Thank you be seated.
Pull the microphone toward you and state your name, please, spelling your last name.
A. Harry Thomas Temple T-e-m-p-l-e.

DIRECT EXAMINATION

BY MR. YAFFA:
Q. Doctor, good afternoon.
A. Good afternoon.
Q. Please take a moment and tell the jury who you are and what

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it is you do for a living.
A. My name is Dr. Tom Temple. I am an orthopedic oncologist at the University of Miami.
Q. What is orthopedic oncology?
A. It is a sub-specialty of othopedics. We specifically treat disorders of tumors of bone and soft tissue in adults and children.
Q. Do you limit your practice solely to orthopedic oncology?
A. I do.
Q. Tell the jury how long that has been the case.
A. Since my fellowship in 1992 to the present.
Q. Currently, you are associated with what institution, sir?
A. The University of Miami.
Q. And you have been associated with the University of Miami for how long?
A. Since 1998.
Q. And can you tell the jury what specifically you do at the University of Miami?
A. My responsibilities are patient care, both operative and nonoperative. I teach residents, medical students and fellows which are residents who completed orthopedic training.
I run the University of Miami Tissue Bank which supplies bone and soft tissue to institutions throughout the United States and, basically, write and publish manuscripts related to orthopedic oncology.

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Q. You say you are in charge of the tissue bank which provides tissue around the country?
A. That's correct.
Q. Tell us what that means. Why would the University of Miami

be providing tissue to other institutions?
A. We do this as a service to provide grafts for patients who are affected by either trauma or tumors where we remove large portions of long bones or the pelvis and then replace them much as you might replace a heart that went bad or liver that went bad, and since we are the oldest tissue bank in the United States, we have established a record of service that makes people around the country want to use our grafts.
Q. How long have you been head of the tissue bank at the University of Miami?
A. This past year. I have been associated at the tissue bank for the past four years. It has been the past year I am in charge of that.
Q. Do you have a formal appointment at the University of Miami?
A. Yes.
Q. What would that appointment be, sir?
A. Professor of Orthopedic Surgery and Oncology.
Q. You are also a Professor of Pathology?
A. That's my secondary appointment, yes.
Q. Tell us about that, please.

A. In that capacity I interact with pathology residents. We teach orthopedic pathology to orthopedic residents and medical students.

I consult in various cases that come in to the University of Miami for second opinions, and I review slides with the staff pathologist.
Q. With regard to the cases you handle as an orthopedic oncologist, do you routinely look at pathology slides?
A. I would say I look at almost every slide and every specimen that I am involved with the care of the patient.
Q. And why is that, sir?
A. Because I think it's very important to be able to correlate the clinical findings with radiographic findings and the pathology. If you look at them in isolation, you can make mistakes.
Q. Do you think you have the ability as a treating orthopedic oncologist after having seen the patient, after having looked at the radiographs, as well as after having looked at the tissue, that you are in the best position to make a diagnosis.
A. I like to feel that way.
Q. Is that why you look at all three of those different items?
A. That's correct.
Q. Can you tell the jury about your education and training, sir?
A. I did my undergraduate education at Harvard University and

subsequent to that went to medical school at Thomas Jefferson University in Philadelphia.

Following that I did an internship in general surgery at Walter Reed Medical center followed, by orthopedic residency at the same institution. I did a fellowship in orthopedic oncology and pediatric orthopedic oncology at Massachusetts General Hospital and Boston's Children's Hospital. Subsequently, I was reassigned to Walter Reed.
Q. What is the Armed Forces Institute of Pathology?
A. It is an organization that is part of the Federal Government that was designed to help pathologists around the country and the world, for that matter, with difficult cases.

It is broken up into various divisions. The particular division I belonged to was the bone division.
Q. And you were there for four years?

A. That's correct.
Q. Can you tell the jury specifically what you did at the AFIP the Armed Forces Institute of Pathology?
A. I reviewed slides, pathologic material of consultation cases, provided orthopedic input, worked closely with the radiologists and pathologists and the soft tissue division as well at that facility.
Q. Do you have any military experience?
A. Yes.
Q. Tell me about that.

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A. I became involved in the military through medical school. I was in the Health Profession Scholarship Program. They paid for my medical training. In return, I was obligated to provide service to the Armed forces. In that capacity I did my internship, residency and subsequent to that paid back a year for each year of training.
Q. Is that how you spent so much time at the Walter Reed facility?
A. That's correct.
Q. Are you board certified?
A. Yes.
Q. Can you, please, tell the jury about that?
A. Board certification in orthopedics is a two-phase process. The first phase is a written examination done immediately after a residency, and the second phase is, basically, an oral examination that culminates after two years of practice and the focus on a specific number of cases you have done.
Q. You passed both the written and oral portion of the exam?
A. I did.
Q. Are you published in your field?
A. Yes.
Q. Tell the jury what areas of interest you had in terms of your research and your publications.
A. Specifically my area of research is orthopedic oncology, bone and soft tissue tumors.

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I have a special interest in tumors of the foot and ankle, and would also have an interest in looking at factors that are associated with important outcomes, specifically metastasis and soft tissue sarcomas and malignant tumors of bone as well.
Q. Do your publications review peer review journals?
A. Yes.
Q. Peer review articles?
A. That's correct.
Q. Books and other monographs?
A. Yes.
Q. Do also participate in reviewing on behalf of peer review journals articles that are submitted to be published?
A. Yes, I do.
Q. Tell us about that, please.
A. The peer review process is whenever manuscripts are sent to reviewers with an area of expertise in a certain field, one reviews those manuscripts, reading them over carefully looking at the bibliographic section and the references throughout the text as well as the statistical analyses and commenting on whether the paper is acceptable for publication in a particular journal or not.
Q. Do you lecture?
A. I do.
Q. Outside the University of Miami?

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A. Yes.
Q. Around the country?
A. Yes.
Q. Are you a member of any professional society or organization?
A. Yes.
Q. Tell us about that, please.
A. I am specifically of the American Academy of Orthopedic Surgeons, which is the general group to which most orthopedic surgeons belong. Muscular-Skeletel Tumor Society, a group within the American Academy of Orthopedic Surgeons. American Orthopedic Society, Florida Orthopedic Society, and the Society of Military Orthopedic Surgeons.
Q. You have told the jury that you have spent time teaching. You spend time in the tissue bank. You spend time researching and publishing, but I want them to get a feel for really what it is you do on a day-to-day basis.
Tell the jury about that, please.
A. For the most part, I do these things, but my primary responsibility is patient care and resident education. On an average day I will see patients in the office. I will do out-patient procedures specifically biopsies and on days when I am not in the office I will be in the operating theater.
Q. If you said the operating theater we are talking about the operating room?

A. Yes.
Q. How many days a week are you actually in the operating room?
A. It varies from week to week. Some days two days a week. Some days four days a week.
Q. Can you give the jury a sense for the kinds of procedures you are doing in the operating room?
A. We do minor procedures such as buy opposite seize. Resections of soft tissue tumors and sometimes major procedures where we resect, remove large portions of bone and joint and replace them with either Al owe grafts which are bones we harvest from cadavers or metal components.
Q. All right. Now you know we are here in this courtroom trying a case that involves the death of Bob Allen?
A. Yes.
Q. Can you tell the jury whether or not you were one of Bob Allen's treating physicians?
A. I was.
Q. Can you tell the jury how it is Bob Allen came under p your care?
A. Dr. Michael whit else who is an orthopedic surgeon in Miami Beach called me to say that Mr. Allen had a what he suspected was either a tumor infection in his foot and asked that I see an evaluate him and treat him with what I thought appropriate.
Q. Did you, in fact do that?

A. I did.
Q. Can you take a couple of minutes and explain to the jury exactly what you did for Bob Allen, what you found when you saw him and the different procedures you got involved in as his treating physician?
A. The first thing I did was take a careful history and did a physical examination and I reviewed his radiographic studies and arranged for him to go to the operating room for an open buy open see. I performed an open buy open see, reviewed the slides and apprised him of the findings and made the appropriate referral to the medical oncologist who was

responsible for delivering the chemotherapy or any other medical support he required.
Q. I want to talk specifically about various aspects of that but before I get into the specifics I want to ask you as a result of your physical exam, as a result of having looked at the films and you did look at the films, did you not?
A. I did.
Q. You did the open biopsy. You took Mr. Allen to the operating room?
A. That's correct.
Q. You cut open his foot or ankle where the cuboid bone is located?
A. The foot.
Q. You actually took the biopsy out?

A. Yes.
Q. Did you look at the pathology yourself?
A. At that time and subsequent to that, yes.
Q. You took into consideration all of the information available to you as his treating physician at that time?
A. Yes.
Q. Did you arrive at a diagnosis as to what it was Bob Allen was suffering from when you completed all those things you just told the jury about?
A. Yes. I concluded that he had metastatic cancer at that time.
Q. Tell the jury what that means.
A. Metastatic cancer is one that arises somewhere initially and, secondarily, goes to bone rather than arising in bone primarily and going somewhere else.
Q. Specifically, the cancer that you found was located where? Tell the jury about that.
A. It was located in one of the many bones in his foot.
Q. Now, as a result of finding the cancer in the bone of his foot, which the jury has heard is called the cuboid --
A. Correct.
Q. -- did you engage, as his treating physician, in reviewing the medical records to try and figure out where the primary cancer was located?
A. We, I believe, were responsible for ordering other tests to

find out where the tumor originated from. Specifically, a bone scan, a chest, abdominal and pelvic CT Scan.
Q. And did you eventually arrive at a conclusion as his treating physician as to where you felt more likely than not his primary cancer was located?
MR. REID: Objection, Your Honor, on the grounds we discussed during break.
THE COURT: Well, he is being asked if he, Dr. Temple, determined, in his medical opinion, based on his factors, where the cancer came from.
I think that's the question. Is there an objection to that?
MR. REID: Yes, sir.
THE COURT: There is objection to that.
I am going to overrule the objection and let him give his medical opinion. The jury will take into consideration what he did and how he did it, and treat the believability of his testimony just like you would anybody else's as to the weight and credibility.
You may answer the question.
Did you arrive at an opinion based upon reasonable medical probability as to where the cancer that you observed

when you operated on his foot originated?
THE WITNESS: Yes, sir.
A. I felt that the most likely source of the malignancy that I

biopsied from his foot was from the lung.
Q. Now, did your role as his treating physician continue after the biopsy?
A. Yes, sir.
Q. Tell us about that.
A. Mr. Allen had other medical problems, specifically diabetes. Subsequent to the biopsy of the foot, he underwent a fairly intensive course of radiotherapy and developed a wound infection at the biopsy site.
I followed along. We did wound dressing changes and, finally, in May of 1999 I took him back to the operating room and cleaned out the area that was infected.
Subsequent to that, I continued to follow him for wound problems and other musculoskeletal complaints he had.
Q. During the time that you continued as his treat physician for the wound problems as you just described for us, can you tell the jury whether or not your opinion remained the same, that Mr. Allen was, in fact, suffering from a primary lung cancer that spread elsewhere?
MR. REID: Same objection. May I have a standing objection?
THE COURT: Your objection is noted and overruled.
Did your opinion change or was it the same?
THE WITNESS: My opinion was the same throughout the course of his treatment.

BY MR. YAFFA:
Q. As you are sitting here today -- it's February 11th, 2003 -- do you have an opinion today, having reviewed all the information available to you in the medical records, knowing Bob Allen went through the radiotherapy, the chemotherapy and the surgeries you did, do you have an opinion today as to whether or not Bob Allen suffered from a primary lung tumor that ultimately resulted in his death?
A. My opinion was he had a lung cancer that resulted in his death.
Q. That's still your opinion today?
A. Yes.
Q. Take a moment and explain to the jury why it is you are of the opinion Bob Allen had a primary lung tumor?
MR. REID: Your Honor, did I understand -- excuse me, doctor.
May I have a standing objection to this opinion testimony?
THE COURT: Well, this is a different question now. He was asked the basis for his opinion.
I presume that it is from your own observation and reports you read from other doctors. Is that right?
THE WITNESS: Yes, sir.
THE COURT: That is the basis of his opinion.
MR. YAFFA: I was going to get specific. I want a

list of the different things.
THE COURT: I don't want him sitting here telling us what all the other doctors he reviewed said.
MR. YAFFA: That's not where I am going, Judge.
BY MR. YAFFA:
Q. Specifically, your reasons for diagnosing Bob Allen as suffering from a primary lung tumor, tell us about that. What

are those reasons?
MR. REID: Excuse me again, Your Honor. That's why I was asking to have a continue objection.
THE COURT: Well, I have asked the doctor, and I will ask him again, was it based on the reports you got from the other doctors as well as your own observations and treatment of your patient?
THE WITNESS: Based primarily on my own observations and treatment of this patient.
THE COURT: Did you rely then on the treatment, the reports you read from -- oh, I don't know the name of a doctor -- anybody, Dr. X, Dr. X?
THE WITNESS: That had influence over the way I felt.
THE COURT: Did you do this over the regular course of your treatment of your patient like you did for everybody else?
THE WITNESS: Yes, sir.
THE COURT: You may answer the question.
BY MR. YAFFA:

Q. Go ahead.
THE COURT: The question was what was the basis of your opinion?
A. First of all, renal cell carcinoma does present sometimes primarily in the context of bone and soft tissue complaints and it is not unheard of to have renal carcinoma patients come in with a complaint of knee pain, for example.
We look at an X-ray and we see an abnormality. We do the staging studies looking at other scans to see where it came from and, typically, what we find is a fairly large renal mass to account for that abnormality.
To present with a tumor in an unusual location like the foot, I would have expected to see a very large renal mass. I did not. Instead, I did see an abnormality in the lung, the upper lobe, that looked like a primary tumor, not a metastatic disease process.
The second reason why I think it's a renal cell carcinoma was because typically why I did not think it was a renal cell carcinoma and predominantly a lung carcinoma was renal carcinomas are extremely vascular. When they go to bone, they attract very large blood supply. When you biopsy a renal cell carcinoma, they bleed extraordinarily. This particular tumor did not bleed.
Q. Hold on right there for a second.
In regard to the biopsy that you did, you are telling

the jury that if it was a primary renal cancer, you would have expected more blood.
Is that right?
A. In general, when you open the bone in patients who have metastatic deposits from renal cell carcinoma, bleeding is significant.
Q. In this case, did you find significant bleeding?
A. No.
Q. Tell the jury the amount of bleeding you encountered when you did the biopsy on Bob's foot?
A. It was relatively minimal. I was able to control it without using a tourniquet, with just direct pressure, and there was such minimal bleeding I didn't even require to place a drain into that area, and there was no significant bleeding in the post-operative dressing, and it did not, was not consistent with what I usually find in patients with renal cell metastasis.
Q. You were telling us the basis for it being a primary lung,

you found a primary lung mass, not a big bulky renal mass. You tell us at surgery, there was no blood.
Tell us the rest of the reasons you feel, as the treating physician, Bob Allen died of --
THE COURT: He didn't say there was no blood. He said it wasn't the massive bleeding one might expect if it was a substantial tumor at that point.

THE WITNESS: That's correct.
THE COURT: Now, answer it with that modification.
Do you want to repeat it?
A. The blood loss was minimal and not of the quantity that I would have expected for renal cell carcinoma metastasis to bone.
Q. Please continue.
A. The other reason I think that it wasn't a renal cell carcinoma and, rather, a lung carcinoma, because his response to radiotherapy was quite good in terms of palliation of pain.
Renal cell carcinoma is a relatively resistant tumor. It does not respond to radiotherapy the way other carcinomas do.
Mr. Allen had fairly long-lasting relief of his pain and discomfort after radiotherapy to his foot, as well as the lumbar vertebra where he subsequently developed a metastatic deposit. Typically, in patients with renal cell carcinoma treated with radiotherapy alone, they will have progressive disease. The disease will become destructive and hard to manage with radiation alone.
Another reason is because the median survival with patients with lung carcinoma is very short, patients with lung carcinoma with metastasis to bone. Whereas patients with renal cell carcinoma with metastasis to bone generally have a longer interval to survival to the time metastasis is diagnosed,

usually measured in years, not months.
Q. Based upon your involvement with Bob Allen, can you tell the time, the length of time between the time of diagnosis and his ultimate demise?
A. I diagnosed the tumor in January, 1999. I believe he died in September, 1999.
Q. Actually, October 1st, about nine months.
The fact Bob survived nine months between the time of diagnosis and his ultimate death is that more consistent with it being a primary lung or primary kidney?
A. I think it is more consistent with being a lung carcinoma, not a renal carcinoma.
Q. Lastly, is there anything about the way the mass looked on the radiographs that enables you to state more likely than not it was a primary lung?
A. Well, in the foot it's very difficult to tell one from the other, but when you have a primary lung mass it's usually more of a central mass and it's usually fairly large and metastasis to the lungs are usually quite small and round and are at the edges of the lung.
Again, I thought that the morphologic appearance of the tumor in his lung was more consistent with a primary lung cancer than it was with a cancer that arose somewhere and went to the lung.
Q. You said when it's a primary lung, it's normally larger and

more central, as opposed to when it's a primary kidney, there will be multiple smaller round lesions.
Is that right?

A. Multiple, rounded, and in the periphery, long.
Q. You did not find that in this case?
A. Not initially, no.
Q. For all the reasons you described for this jury, is it still your opinion, as Bob Allen's treating physician, he died of a primary lung cancer?
A. Yes, it is my opinion he died of primary lung cancer.
MR. YAFFA: Thank you very much.

CROSS EXAMINATION

BY MR. REILLY:
Q. Good afternoon, doctor.
A. Hello, sir.
Q. I will be with you in just a minute, doctor.
We have never met before. Correct?
A. That's correct.
Q. Doctor, you were one of a number of physicians who cared for Mr. Allen. Correct?
A. That's correct.
Q. Okay.
And there were physicians of a number of specialties who cared for Mr. Allen. Correct?
A. That's correct.

Q. And included among those physicians were doctors who were given the task of addressing his cancer in terms of identifying where it was coming from. Correct?
A. That's correct.
Q. And those physicians included Dr. Sridhar?
A. Yes.
Q. You know or you knew Dr. Sridhar?
A. Yes.
Q. He ended up being Mr. Allen's primary care physician before for his cancer, didn't he?
A. Yes.
Q. Dr. Sridhar has died?
A. Yes.
Q. We can't bring him here today?
A. I wish we could.
Q. Wish we could.
Dr. Sridhar asked that the tissue that you biopsied be sent to the pathology department at Jackson memorial. Correct?
A. That's correct.
Q. It wasn't sent to you to review at the pathology department there, was it?
A. I should clarify that the biopsy was done at the University of Miami Hospital and Clinic which is a component of Sylvester Cancer Center. The same pathologists who reviewed the pathology at Sylvester Cancer are the same as Jackson Memorial.

Q. I realize you have a couple of different hats that you wear, but in this particular case, the original surgical pathologist who examined the specimen you took from the cuboid bone of Mr. Allen was not you?
A. That's correct.
Q. It was Dr. Civantos. Correct?
A. I am not certain as to who the initial pathologist was.
Q. Let me see if I don't have that.
Doctor, have you ever seen this report?
A. Yes.
Q. On it -- this is the official report from the pathology department, one of the official reports. Correct?
A. That's correct.
Q. This was prepared not by you, but you by Dr. Civantos?

A. Dr. Civantos' name is on it.
Q. I didn't know you were going to go talk to us about pathology.
I think everyone will agree Dr. Civantos did the original pathology report?
A. All right.
Q. You know Dr. Civantos?
A. Yes.
Q. A very respected pathologist?
A. He is.
Q. A professor of pathology?

A. Former professor of pathology.
Q. His diagnosis, based on his review of the pathology, was metastatic poorly differentiated carcinoma. Correct?
A. That's correct.
Q. He makes a couple of observations about the appearance of the cells. Correct?
A. Yes.
Q. That's called the morphology of the cells?
A. That is, basically, the morphology or the growth pattern he is describing, yes.
Q. Now, when it says metastatic poorly differentiated carcinoma, that tells you and other doctors a lot, doesn't it?
A. It does.
Q. It tells you that we are dealing with something that is not a cancer that arose in Mr. Allen's cuboid bone. Correct?
A. That's correct.
Q. And now there is going to have to be a search to determine where in the world this cancer came from, isn't there?
A. Yes.
Q. And that's hard, isn't it?
A. It can be.
Q. That's an imprecise science, isn't it?
A. It can be.
Q. In this case, Mr. Allen had cancer in a variety of locations of his body, didn't he?

A. At the time, yes.
Q. And he had, unlike people who arrive with a nonmetastatic kidney cancer and nonmetastatic lung cancer, this is a fellow whose cancer had already spread to many parts of his body?
A. He had other sites of involvement, yes.
Q. He was recognized on the very first visit with Dr. Sridhar as a terminal patient, wasn't he?
A. That I am not certain of.
Q. Did you ever talk to Dr. Sridhar about this patient?
A. We had spoken about his care and diagnostic quandaries.
Q. Quandaries, right.
What you now know, having seen the reference to metastatic poorly differentiated carcinoma, is that it didn't start in the foot?
A. Right.
Q. And you don't know where it started at this point, do you?
A. At this point, no, sir.
Q. As a matter of fact, you never knew for sure where it started, do you?
A. Not with absolute certainty, no.
Q. There is now going to be some investigative research on your part and on the part of the other doctors whose job it is to care for this patient. Right?
A. Yes.
Q. You may not all agree on where this cancer started.

Correct?
A. That's correct.
Q. As a matter of fact, it's not uncommon at all for doctors as qualified as you, as qualified as Dr. Sridhar, as qualified as Dr. Civantos -- and in a minute we'll see Dr. Nadji -- as qualified as Dr. Nadji, did not agree where the cancer started?
A. It is true in the minority of cases there is not always common agreement.
Q. Have you looked at the pathology reports in recent times from Dr. Civantos and Dr. Nadji?
A. I looked at Nadji's recently. I don't know I went back and looked at Civantos' in the last several months or years.
Q. Okay.
You looked at Dr. Nadji's in anticipation of giving testimony in this trial?
A. Yes.
Q. You didn't do it because you were doing some research project or you just had an interest in this particular patient's records?
A. Interestingly, we were doing a research project on metastatic tumors of the foot, and that's how we did come across this case relatively recently.
Q. Okay.
As a matter of fact, metastatic lesions to the foot from distant locations are quite rare, aren't they?

A. Yes, they are.
Q. And they have been the subject of a few publications over time, haven't they?
A. A few, yes.
Q. And we will talk about those in a minute, but you are familiar with some studies that have come out of the Mayo Clinic?
A. Yes.
Q. Studies that have come from schools of podiatry, publications involving podiatry?
A. I don't read the literature much.
Q. I understand.
We will talk about that in a minute, because this is a pretty rare situation.
A. It is a rare situation.
Q. Number one, we are dealing with a situation in which we know it didn't come from the bone in the foot. We know we are dealing with a rare situation. Right?
A. Yes.
Q. How often do you encounter this problem?
A. We have identified ten cases in over 5,000 bone tumors.
Q. It is very rare, isn't it?
A. It's rare.
Q. Of the 5,000 bone tumors, how long does that take to accumulate?

A. That was over a twenty-three year period.
Q. Five cases out of a twenty-three year period?
A. Ten cases.
Q. I'm sorry. I apologize.
Ten cases out of a twenty-three year period?
A. Yes.
Q. At this point, you would characterize the information you have as leading you to an occult primary. Correct?
A. At this point I couldn't call it occult because we hadn't had the staging studies to classify it as an occult.

An occult tumor is one where you can't identify the primary tumor. We hadn't looked prior to this.
Q. All right.
The next line down says nesting pattern and partially clear cells. Correct?
A. Yes.
Q. Nesting pattern is a common appearance for renal cell carcinoma. Correct?
A. And other types of carcinomas as well.
Q. I understand.
But that's clearly consistent with a renal cell carcinoma?
A. A nesting pattern can be seen with some types of renal cell carcinoma.
Q. There are a couple of well-known types of kidney cancers,

aren't there?
A. Yes.
Q. One is renal cell carcinoma.
MR. REILLY: Could you read the question back?
[The requested text was read].
BY MR. REILLY:
Q. I am going to abbreviate renal cell carcinoma as RCC. That is the common abbreviation for it?
A. Yes.
Q. What is the other most common type of kidney cancer?
A. Clear cell carcinoma.
Q. Isn't renal cell carcinoma clear cell?
A. There are several varieties.
Q. Is there a transitional carcinoma?
A. That, generally, comes from the ureter, bladder. It can also come from the renal cloasis, the collecting system.
Q. Right. Different disease. Right?
A. It behaves differently, yes.
Q. And has a different origin. Right?
A. It does.
Q. What is the abbreviation for that? Do you know or should I just call it transitional?
A. TCC.
Q. Now, what Dr. Civantos is talking about here is the RCC version. Correct?

A. I believe that's what he is talking about, yes.
Q. And that's consistent with partially clear cells, isn't it?
A. It's consistent with clear cells in the well-differentiated form of disease and the spindle cells as it becomes more differentiated.
Q. You never talked to Dr. Civantos about this?
A. I have talked to Dr. Civantos about this case, yes.
Q. Nesting pattern, partially clear cells, his differential diagnosis was partial renal cell carcinoma?
A. That's correct.
Q. This is based on looking at the -- you know what I think, we have skipped a step for the jury.
The first thing that happens is the tissue is sent down to the pathology department. Correct?
A. At the time of the biopsy, the tissue is sent to the frozen section room, which is right adjacent to the operating theater. They look at it preliminarily to make sure that the tissue that I have gotten is diagnostic, not necessarily I have adequate tissue to make a diagnosis. Then it goes to the main pathology lab for further processing.
Q. The processing consists of mounting it so that it can be

looked at on a slide under microscope, a portion of it?
A. In a sense, yes.
Q. And then that is what Dr. Civantos does. He looks under a very high-powered microscope and looks at the appearance of the

cells. Correct?
A. Yes.
Q. And then he comes to a conclusion as to what he thinks most probably these cells look like. Right?
A. Yes.
Q. And he has reported that here. Correct?
A. Yes.
Q. And he also included in the differential -- when I say "differential diagnosis," that means possibilities. Correct?
A. Yes.
Q. Nothing is for sure here, is it?
A. That's correct.
Q. And it never will be in this patient, will it?
A. Well, I am not certain that is the case, but I think that there have been questions all along, yes.
Q. All along.
Doctor, he also included squamous carcinoma as a possible diagnosis?
A. Correct.
Q. Squamous cells can come from a variety of locations in the body?
A. Yes.
Q. It can come from your throat?
A. Yes.
Q. Your lung?

A. Yes.
Q. It can come from other organs in your body. Right?
A. Yes.
Q. Dr. Civantos requested more work in an effort to clarify where this cancer may be coming from. Correct?
A. He ordered more stains, yes.
Q. More stains?
A. Yes.
Q. And he asked a particular physician to do that. Right?
A. Yes.
Q. A very well known physician?
A. Dr. Nadji.
Q. Dr. Nadji enjoys a great reputation in terms of his expertise in immunohistochemical stains?
A. That is Dr. Nadji's area of interest.
Q. Not an area of interest, but an area of extreme expertise?
A. We differ at some times.
Q. And, again, you just mentioned you and Dr. Nadji don't always agree. Right?
A. That's correct.
Q. You guys can differ because this is an inexact science, isn't it?
A. Immunochemistry certainly is.
Q. It is a field of science that is just growing now, isn't it?

A. Certainly advances are made every month in this area.
Q. And there is not complete agreement on what the appearance of these immunohistochemical stains truly mean. Correct?
A. That is true.
Q. But, Dr. Civantos ordered several new stains to be applied to mount tissue. Correct?

A. That's true, he did. He ordered those stains that are mentioned.
Q. Renal cell antigen, CEA. That's an abbreviation for a type of stain. Correct?
A. That's correct.
Q. Keratin, that is a --
A. There are a number of different keratins. I think it is a general term. Whether it is epithelial, again, I am not sure. Keratin is an epithelial marker.
Q. Do you know which of the keratin stains Dr. Nadji applied?
A. He didn't specify.
Q. To follow from Dr. Nadji at the University of Miami. Right?
A. Yes.
Q. Did you look at the -- did you look at Dr. Nadji's report?
A. I looked at Nadji's report.
Q. In Dr. Nadji's report the findings were consistent with a renal cell carcinoma, weren't they?
A. Based on the limited number of immunochemical markers he

ordered, that's my impression.
Q. And that's what he reported. Right?
A. Yes.
Q. I didn't highlight it, but that is the results of Dr. Nadji's report with a later report at the bottom. Right?
A. Yes.
Q. And I put it so that arrow is right in the middle of the report, which is kind of unfortunate.
A. That's all right.
Q. What he found were positive for keratin and epithelial membrane antigen, negative for renal cell antigen, carcinoembryonic antigen and prostatic specific antigen.
Those were the stains he felt important to do?
A. Yes.
Q. Based on the results of those stains, his conclusion was this was most probably a renal cell carcinoma. Correct?
A. Which is where Dr. Nadji and I differ.
Q. That is the mystery of this science. Right?
A. That's the mystery of this battery of tests.
Q. That's where your science is today. Correct?
A. Yes.
Q. You are not being critical of Dr. Nadji?
A. He is a fine pathologist.
Q. He is not critical of you, I am sure.
The quandary then for Dr. Sridhar was he had the

results that indicated to Dr. Nadji, Dr. Civantos, that this most probably was a renal cell carcinoma. Correct?
A. That he thought the battery of tests he performed, for reasons that only he can explain, were most consistent with renal cell carcinoma.
Q. All right.
So, you know that Dr. Sridhar then asked for more work of a different kind, not pathology, but a different kind of work to be performed. Correct?
A. I am not sure what you are getting at.
Q. Well, do you recall Dr. Sridhar wanted an evaluation for kidney lesions?
A. He ordered other scans, yes.
Q. Now, that's moving to a different area of medical expertise. Correct?
A. Yes.
Q. Now, we have left the pathology department. This is how

difficult this task is, isn't it?
A. It could be very difficult.
Q. This is the hunt for what is the cause of Mr. Allen's cancer. Correct?
A. Yes.
Q. What happens next is Dr. Sridhar asks for more radiographs to be taken of Mr. Allen's body. Right?
A. Yes.

Q. He is interested in radiographs of both the chest and abdomen?
A. And pelvis, yes.
Q. And pelvic region, because he is concerned about a kidney cancer and lung cancer because there is a reference to squamous here?
A. I could see how he could be concerned about all those cancers, because the only thing identified was it had an epithelial origin, but everything else, kidney, lung, prostate specific markers were negative.
Q. Now, if Dr. Sridhar is like you, he may be familiar with the Mayo Clinic study which talks about metastasis to bones in the foot. Right?
A. Yes.
Q. And the study we are talking about, that you and I are talking about that we haven't shared with the jury yet is a study by Call, Simm and Pritchard. Correct?
A. Yes.
Q. In your world, even though this is a very rare disease, this is a pretty famous study. Right?
A. Those are famous people reporting on that, yes.
Q. Their finding was their series added to the accumulating reports indicating that many metastatic foot lesions arise from the genitourinary track. Right?
A. Yes.

Q. That's the kidney included. Right?
A. Kidney, ureter, bladder, urethra, yes.
Q. It is a red flag.
You have a distant metastasis to a bone in the foot and what literature there is on the subject says be looking for a genitourinary tract lesion cancer?
A. Certainly kidney would be in the differential. Any aggressive foot metastasis.
Q. Dr. Sridhar signs this document?
A. Yes.
Q. You can see his thought process right here, can't you?
A. Yes.
Q. He is puzzled. He says "We need an MRI of the kidney. If negative, favor left lung clear cell carcinoma and order chemotherapy." Right?
A. Yes.
Q. If the MRI of the kidney is positive, then he is going to figure it's a renal primary and transfer to Dr. B. Right?
A. Dr. Benedetto.
Q. To treat him for a kidney cancer?
A. Yes.
Q. Now, there you have it. That is the quandary Dr. Sridhar is in?
A. At this point, yes.
Q. Did you look at the MRI of the kidney?

A. I had looked at it, yes.
Q. Did you look at the report of it?

A. I probably did, but I don't recall the exact substantive report, yes.
Q. It didn't even report on whether or not there was a kidney cancer, did they? They talked about renal vascular sufficiency or something like that. They missed the whole point, didn't they? Do you remember?
A. I don't recall. I'm sorry.
Q. Unfortunately, they didn't address the question Dr. Sridhar was posing, did they?
A. Well, if they did a CT Scan of the abdomen and didn't see an abnormality in the kidney, then, perhaps, they did.
Q. I will show you that record in just a minute. I didn't bring it up here with me. We have never spoken and I didn't know what you were going to talk to us about.
Doctor, you have looked at the CT Scan of the abdomen.
A. In the past I had, yes.
Q. It was interpreted by a Dr. Messinger. Correct?
A. I don't know that.
Q. Well, do you know whether or not -- do you know why that CT Scan was sent out to be read by somebody not at Jackson or --
A. No, sir, I don't know why that was the case.
Q. Have you, personally, looked at the CT Scan of the abdomen?
A. It was a long time ago. I just don't remember.

Q. Do you know whether or not a kidney tumor was missed on that CT Scan?
A. I just don't know the answer to that question.
Q. Do you know whether or not in this lawsuit Dr. Messinger has acknowledged that he missed a tumor on that CT Scan?
A. I did not know Dr. Messinger had commented as such.
Q. Well --
A. I must say, I don't know Dr. Messinger either.
Q. I understand.
According to that game plan, if the CT Scan of the abdomen had come back with a report of a tumor on the kidney, you know what the plan was, don't you?
A. As is delineated there.
Q. And today is the first time you have ever heard there was a tumor on the kidney. Right?
A. No. I understood there was an issue with renal cell carcinoma and radiographic appearance late in this gentleman's course of disease, that a renal cell carcinoma to the kidney may have been present, but I did not know early on in this staging process that there was radiographic evidence of renal cell carcinoma.
Q. Small kidney cancers can be quite aggressive, can't they?
A. I am not sure I understand that question. Any cancer can be very aggressive, depending on its grade and its ability to take up residence in another part of the body.

Q. Small kidney cancers can metastasize, can't they?
A. Yes.
Q. The treatment for a kidney cancer is different than the treatment for lung cancer, isn't it?
A. Yes.
Q. Among the few -- I will use the word armaments. What I mean by that -- that's a poor word -- among the few treatment possibilities for kidney cancer is one called IL-2?
A. Yes.
Q. It is not always effective. Sometimes you can achieve a positive result from IL-2. Correct?
A. You can achieve a complete response in about five percent of patients, partial response in up to twenty percent.

Q. For kidney cancers, the treatment that you provide for a patient who suffers from -- I'm sorry. Let me start the question again.
For patients who suffer from kidney cancer, the treatments that you would ordinarily order for an adenocarcinoma of the lung are not going to be effective, are they.
A. I'm sorry. Can you repeat the question?
Q. You bet. It's kind of an odd question. I apologize.
If you have a patient who has a kidney cancer --
A. Yes.
Q. -- if you treat them with cancers that you would

ordinarily use for an adenocarcinoma --
A. If you treat them with drugs that you would typically use for adenocarcinoma?
Q. Drugs, radiation, what you would ordinarily do for an adenocarcinoma of the lung, you are not going to positively impact a kidney cancer, are you?
A. The likelihood is no.
Q. So, you would expect to see, if you were treating somebody who really had a kidney cancer and if you treated them as if they had as their primary cancer an adenocarcinoma of the lung, you wouldn't expect to see any improvement, would you?
A. If you treated a patient with a kidney cancer with drugs typically reserved for cancer of the lung, you probably would not see a response.
Q. Okay.
But if you treated the patient that had kidney cancer with IL-2, you might, in fact, see an improvement. Correct?
A. You may.
Q. No guaranty?
A. Correct.
Q. But you might?
A. Correct.
Q. You mentioned you do know at a later point in time a tumor on the kidney was identified. Correct?
A. Yes, as well as many other sites.

Q. Unfortunately, that didn't occur until August, did it?
A. Right.
Q. Roughly eight months after this initial quandary that Dr. Sridhar was in. Right?
A. I don't know the precise date. My recollection was it was later in the course that treatment had been switched.
Q. And by -- have you seen that CT Scan? Have you seen that ultrasound?
A. I don't believe I have.
Q. Have you heard whether or not that was a rather large tumor at that point?
A. No.
Q. All right.
Do you know whether or not Dr. Messinger in this case has acknowledged that the tumor that was identified in August was the same tumor he missed in January?
A. I didn't know there was, that was an issue, to begin with. I didn't know the follow-up to that.
Q. Doctor, there is no, there is no given time frame that people survive, is there?
A. For particular cancers, there are mean survival times. For example, for patients with lung cancer, the mean survival is somewhere around six months. For breast cancer, two and a half years. For other types of cancer, it is quite unpredictable.

Q. You have patients who when you see them and they suffer

from bone cancers or other cancers, you tell them "I think you may survive" -- because they all want to know. Right? They want to know --
A. But I never tell them specific times. I think it's very difficult to predict, and I don't know the precise answer to that question.
People respond to treatment differently. I don't tell people a specific time interval.
Q. How long Mr. Allen survived is a pretty soft basis for making a diagnosis, isn't it, or where his primary cancer came from?
A. It is not the only reason I would choose to discuss.
Q. I understand.
You have built your -- I don't want to call it an argument -- but you have built a series of reasons why you have an opinion as to where this cancer came from.
A. Yes, sir.
Q. Unfortunately, you didn't know.
You included in your opinion that there was, in fact, a kidney lesion on day one when this CT Scan was performed, did you?
A. It was clear to me later in the course that he did have. However, had I known that piece of information it's not uncommon for lesions that arise in the lung to metastasize to the kidney, for example, the liver, bone and any other site, in

fact.
Q. Let's talk about that, because it can go both ways. Right?
A. Yes.
Q. A tumor that starts in the lung can metastasize to the kidney. Right?
A. Yes.
Q. When it does, you expect to see more than one tumor in the kidney. Right?
A. Not always.
Q. Nothing is always, is it, doctor?
A. But you would more likely see a solitary metastasis from a lung primary going to the kidney than you would from the kidney going to the lung.
You would more often see multiple nodules in a lung and a very specific distribution.
Q. We will get to the lung in just a minute.
Ordinarily, what you find in a metastasis to either direction, you would ordinarily find more than one site in the metastasized site. I probably said that wrong. I probably said that like a lawyer would.
Wherever it is going to, you would probably see more than one lesion there?
A. Statistically.
Q. Where it has come from, you would expect to see the solitary lesion more often?

A. Right.
Q. Now, how many lesions were found in the kidney?
A. Since I didn't see the scan, it's not clear to me how many were found in the kidney. I know that he had --
Q. Assume for me one was.
A. Okay.
Q. How many lesions were found in the lung?
A. Well, early on --
Q. First day.

A. The large mass in the upper lobe was the one that I had focused on.
Q. Do you know if there were other lesions in the lung?
A. I don't know that.
Q. Did you look at the CT Scan on the lung?
A. I did.
Q. Did you see a left lower lobe lesion?
A. I didn't at the time, no.
Q. Did you miss it?
A. Perhaps.
Q. Do you know if it was reported on by later radiographic procedures?
A. No.
Q. Do you know if the same Dr. Messinger has acknowledged that there is, in fact, a left lower lobe lesion visible on the very first CT Scan?

A. No.
Q. Multiple lesions in the lung would be more consistent with metastasis to the lung, wouldn't they?
A. At what point in time?
Q. Day one, January, 1999.
A. Multiple lesions often are consistent with metastatic disease processes.
Q. Without a biopsy, it is not possible to determine for sure whether or not a lesion is cancerous or not. Right?
A. That's correct.
Q. And no biopsies were ever taken from the lung?
A. That's correct.
Q. No biopsies were ever taken from the kidney?
A. I assume that's the case. I don't know.
Q. Okay.
And no autopsy was ever performed?
A. No autopsy was ever performed.
MR. REILLY: No other questions, Your Honor.
THE COURT: Mr. Reid, any questions?
MR. REID: I have no questions.
THE COURT: Redirect.
MR. YAFFA: Thank you, Judge.
REDIRECT EXAMINATION
BY MR. YAFFA:
Q. Dr. Temple, just a couple of follow-up questions for you.

Mr. Reilly asked you a number of questions about Dr. Nadji. Do you recall them?
A. Yes.
Q. And you indicated that Dr. Nadji's opinion was based upon the battery of tests, the immunohistochemical stains he chose to do?
A. That were ordered.
Q. I think the quote was a mystery of the battery of tests that were done?
A. Yes.
Q. Were there additional tests you are aware of that may have shed more light on where the primary tumor was likely to have arisen from?
A. I think other tests could have been done to be more complete. If you choose to only look at a number of relatively nonspecific tests that have fairly high incidents of false negative and false positive, then it really doesn't become a source of enlightenment, but rather one of confusion.
I would have probably relied more heavily on the standard HNE and the clinical history and the way the disease

evolved.
Q. And for whatever reason, Dr. Nadji chose not to do those other tests. Correct?
A. I assume.
Q. As you sit here today, you are aware we have since sent out

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the pathology to be tested by Dr. Sam Hammar in Seattle?
A. Yes.
Q. Do you know Dr. Sam Hammar?
A. I know him by reputation.
Q. Is he a respected pulmonary pathologist?
A. Yes.
Q. You said given the test Dr. Nadji chose to use, you would have chosen to rely on the clinical and radiographic evidence to make a decision of what the primary was?
A. I wouldn't look at something in isolation. I think when you do that you run the risk of making errors.
An analogy, what one of my professors said, if you came from Mars and you wanted to know what a desk looked like and you were blind and you felt around the desk and picked up a pen or some object on the desk, you would have a very bad idea of what a desk was than if you looked at the whole picture, and for that reason I think when you rely on studies like immunohistochemistry, we are just looking at slides in isolation. You run the problem of making an error.
If you don't put it all together with the radiology and the clinical history, then I think you don't have all the information you need to make the right diagnosis, and that's what Dr. Jaffe had recommended in the early '40s, specifically when it came down to bone pathology.
Q. In this case when you look at the whole picture, everything

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that's available to you, are you of the opinion, more likely than not, within a reasonable degree of medical probability as a treating orthopedic oncologist, Bob Allen's treating orthopedic oncologist, he had primary lung cancer?
A. For the reasons I mentioned, I felt his primary disease was lung.
Q. Mr. Reilly asked you about a drug called IL-2, Interlucan-2?
A. That's correct.
Q. Do you have specific knowledge as you sit here today as to whether or not Bob Allen was initially treated for lung cancer, was eventually switched to Interlucan-2 during the course of his treatment before his death?
A. He was switched to Interlucan-2 before his death.
Q. Tell the jury about that. What were the circumstances under which he was switched to IL-2?
A. It was my understanding at the time -- and I am not the person who administered the chemotherapy --
MR. REILLY: I object, Your Honor, if he is speculating as to what the cause of the change was.
MR. GROSSMAN: This was on cross.
THE COURT: All right. It would be just something told to him by the other doctor. He told us he did switch to that.
MR. YAFFA: Yes, Your Honor. As a treating

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physician -- they brought this up on cross -- he is aware of the circumstances under which the switch took place.
THE COURT: But he didn't order it himself. He has no knowledge, except what he was told by the other doctor.
If it is important, you can bring the other doctor in.

MR. YAFFA: The other doctor is dead.
THE COURT: Then it would be double hearsay, wouldn't it? It would really be a difficult thing. If he had written it in a report, that might be usable, but the objection is sustained.
BY MR. YAFFA:
Q. There was discussion regarding Dr. Benedetto.
A. Yes.
Q. As you sit here today, do you know whether or not Dr. Benedetto got involved in this case?
A. Dr. Benedetto got involved because he is the oncologist I specifically use for sarcomas and GU cancers.
When the case was put forth in our conference, it was felt that the disease was more than likely not genitourinary, but lung, and that's why Dr. Benedetto was the treating doctor.
Q. Dr. Benedetto's opinion regarding whether or not this was a primary lung or primary kidney, what did you find out, please?
A. That he decided it was a primary lung cancer and decided Dr. Sridhar was the best person to take care of him.
Q. You were asked questions about whether or not there was

actually a kidney lesion in this case from day one.
A. I recall the question being answered or asked.
Q. By Mr. Reilly.
In this case we know that Mr. Allen had cancer that had spread everywhere. Correct?
A. He had multiple sites of disease dissemination.
Q. What were some of the other sites from the lung you think the cancer spread to?
A. I believe he had liver involvement. He had involvement of the L-4 vertebra as well as the cuboid. This wasn't at presentation. He ultimately developed this. He had involvement, I am told, of a kidney.
Q. I want you to assume for the purpose of this question that when that initial CT Scan was done that showed that 1.6, about 1.8 centimeters of spiculated mass that you indicated that was a reason why you think it was a primary lung.
I want you to assume further there was a small cyst on one of the kidneys that was not commented on because the radiologist did not think it was significant.
Number one, do primary lung cancers spread to the kidney?
A. Yes.
Q. If there was a small cyst or lump there that wasn't commented on, does that change your opinion in any way, shape or form that Mr. Allen had, in fact, a primary lung cancer that

spread elsewhere?
MR. REILLY: I object, Your Honor. That isn't going to be the testimony in this case. So, it is an inaccurate hypothetical.
THE COURT: Well, hypotheticals have to be based on the evidence in the record.
Now, you all have -- there are 736 exhibits in this record. I don't pretend to be totally familiar with all of them, although, unfortunately, I have had to read or look at every one -- excuse me -- scan, but I wouldn't understand a lot of what I was reading, in any event. I have to rely on counsel here.
We have a dispute as to whether or not this is by way of an exhibit in the record or not.
I don't know how to resolve that. I certainly believe counsel, either counsel's representation to me. I suppose

about all we can do is take a short recess while we attempt to locate whatever document may bear out the opinion of the lawyers, whether or not this is part of the record.

If it is not, then the doctor, it cannot be part of the doctor's hypothetical question. Normally, experts can answer hypothetical questions. However, they must be based on what is in the record.

The only way I can resolve this, if we wish to keep going in this area, is to excuse the jury a few minutes and let

counsel, both counsel, locate whatever they may have on that.

MR. YAFFA: Your Honor, it is my final question. It is clearly in the deposition. If the Court wants me to locate that for you, I can do that rather quickly.

THE COURT: In the deposition?

MR. YAFFA: And Dr. Messinger is going to come in and testify to these facts.

MR. REILLY: Your Honor, I will withdraw my objection. I will let this hypothetical stand and we will see what Dr. Messinger comes in and acknowledges.

THE COURT: All right.

Based on the representation that the evidence is forthcoming, the question will be asked.

Now, let's go back, if we can, so we don't get into problems.

Can you repeat it?

MR. YAFFA: I think I can do it, Judge.

BY MR. YAFFA:

Q. Doctor, I want you to assume hypothetically from day number one, January 16th, 1999, on that CT Scan where you saw that spiculated mass that was measured to be 1.6 to 1.8 centimeters, in the left upper lobe there was also a small, I am going to call it a hump or lump -- Dr. Messinger will say he thought was a cyst that wasn't commented on for that reason -- assume that to be true. Does that in any way, shape or form change your

opinion in this case that Bob Allen had a primary lung mass that metastasized to all these other locations and resulted in his death?

A. Yes.

Q. It is still your opinion, knowing that, that Bob Allen had a primary lung cancer?

A. Yes.

Q. Thank you.

MR. REILLY: Your Honor, may I ask one question on the document we haven't seen before?

THE COURT: Which document?

MR. REILLY: I don't mean I haven't seen it before. It wasn't used on direct exam.

THE COURT: Was he asked anything about this document?

MR. REILLY: Yes, he was.

RECROSS EXAMINATION

BY MR. REILLY:

Q. Doctor, this document indicates that Dr. Benedetto feels this is a lung primary because there are lung lesions and no kidney lesions. Correct?

A. Yes.

MR. REILLY: No other questions.

Thank you, Your Honor.

THE COURT: All right.

Thank you, doctor. You may step down.

All right, ladies and gentlemen. Before we go back

with the rest of the -- well, go back to the other doctor that was on or whomsoever they are going to call next, we will take a brief recess.

You folks can step into the jury room.

[The jury leaves the courtroom at 3:02 p.m.]

[There was a short recess at 3:02 p.m.].

THE COURT: Thank you.

Bring in the jury, please.

[The jury enters the courtroom at 3:30 p.m.]

THE COURT: Thank you. Be seated.

All right. You will recall, ladies and gentlemen, we took Dr. Temple out of turn and Mr. Reilly and Mr. Reid had delayed their cross-examination of Dr. Feingold until this point in time.

So, now we will go back an pick up at that point with Mr. Reid on cross-examination.

MR. REID: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. REID:

Q. Good afternoon, Dr. Feingold.

A. Good afternoon.

Q. I am Ben Reid. We have never met although I don't think we live far apart in the south part of town. In fact, all my children were born at your hospital.

A. That is a good place to be born.

Q. Let me ask you a couple of questions about South Miami Hospital in general.

You said there is a division of pulmonary medicine there

A. Correct?

Q. You were the chief of that at some point or you are today?

A. I am today.

Q. You have doctors on staff who are doctors that have privileges to come in from their offices and treat their patients at your hospital?

A. Yes.

Q. Aside from that the department of pulmonary medicine at South Miami, of which you are the chief, has two in-house pulmonologists?

A. Correct.

Q. South Miami is not a research hospital?

A. That's right. Some research is done there, but it is not a teaching hospital or academic hospital.

Q. You are not involved in research either, are you, sir?

A. I am not.

Q. You don't teach?

A. I do teach, actually. I think in a couple of weeks I am going to be teaching at the University of Miami and at Jackson.

I have been asked, I have been asked each year for a

couple of years to teach a course on lung cancer to the resident physicians, family resident physicians.

But I am not a teacher. I am primarily a clinician.

Q. So, if you said when you were deposed you currently don't have any teaching responsibilities, that would be accurate?

A. That is true. I am invited from time to time to teach. I am going to teach on Friday in Indianapolis. I don't have any teaching positions assigned.

Q. And the South Miami pulmonary department focuses on asthma. I think you mentioned that today.

A. No. It focuses on different lung diseases. Asthma would be one of them.

Q. And sleep disorders?
A. That would be one of them as well, sure. We have a sleep laboratory.
Q. And shortness of breath during exercise?
THE COURT: Can you run a little bit of a test here on courts in the late afternoon after we have had a heavy lunch?
THE WITNESS: I don't need a test for that. I will try to prevent it, though.
THE COURT: Mr. Reid, that was terribly rude of me to interrupt you. I was trying to make sure we all stay a wake here this afternoon.
BY MR. REID:
Q. Shortness of breath during exercise, that's one of the

areas on your website?
A. That's the kind of thing we would study. We do exercise tests, what's called cardiopulmonary exercise tests to help figure out why people are short of breath during exercise.
Q. You also have something called a hyperbaric chamber?
A. I am certified by the National Oceanic Association. There are few such people in the country. Most of those people were trained by the military. I was trained by NOA. We have a hyperbaric chamber, one of the first ones in Miami. I have been doing that for twenty years.
Q. That is to treat divers who might get the bends otherwise?
A. We certainly do treat that, although we treat carbon monoxide poisoning and treat a lot of other complex problems. People with nonhealing diabetic wounds, for example.
Q. You do a bunch of different things you told us about?
A. I don't do that many. I do concentrate on some, but it's mostly within pulmonary.
Q. I think you said, you told us in your deposition, say, in the year 2002, about half your working time was on clinical activities?
A. Roughly, yes.
Q. You told us there were sometimes, weeks and even months, where, essentially, all the work you might be doing is litigation-related work. That you told us about?
A. That's true, and, equally, weeks or -- well, weeks, anyway,

when all the activity is clinical.
Q. You gave us your opinions here today about the origin of this particular cancer?
A. Yes, sir.
Q. And you based it on all the things you told us about?
A. Yes.
Q. You hold those opinions very firmly, it sounds like.
A. I hold them as firmly as a lung specialist can hold things, and I know I have been asked to answer to a reasonable degree of medical certainty, which is a legal test, and I know about that, but I do hold the opinions to a greater degree of certainty than that.
Q. But, I mean, you firmly believe the opinions. You don't believe there is really any question about where this cancer originated?
A. I don't think that's fair. I think that a doctor is required to question. I think that the process of diagnosis is a constant process of suggesting a diagnosis and then trying to defend it against opposition.
Q. Okay.
A. That's the process called differential diagnosis. It is very similar to other academic activities where you propose a thesis and then you anticipate the thesis to be criticized or

attacked. I think all of that is the process.
I certainly maintained healthy skepticism about the

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source and origin of this cancer before I came to a conclusion.
Q. And you came to that conclusion when you prepared your report in this case. Is that right?
A. Absolutely. And the preparing of the report is part of the conclusion-making process. You are right.
Q. So, the jury understands, you actually wrote out a report and it was submitted in this case and handed out to all the lawyers?
A. Yes, that's exactly right.
Q. We will get to that in a minute.
You also then gave your deposition. Do you remember that date?
A. I don't remember the date, but I have a copy of the deposition here.
Q. It looks like it was December 9th, 2002.
A. Sounds right.
Q. And you had, whatever you had done prior to that date, you had done enough, in your opinion, to reach the conclusions that you have testified about here today?
A. Correct.
Q. And, well, let me ask this question regarding whether or not you hold your opinions firmly and what you just said about them being defended and so forth: Would you agree that in this case, that is, the case, the medical case of Mr. Allen from start to finish, that there were serious questions all along

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about the origin of this cancer? Would you agree with that?
A. I think there were questions, certainly. That was a very healthy, healthy attitude among the doctors. I really like to see that and I think that's what people are supposed to do.
I think the questioning and the self-criticism is what doctors are supposed to engage in, but I think that the conclusions were always that, ultimately, that the patient had primary lung cancer, and I agree with the treating physicians that that is what he had.
Q. Say that again. Ultimately --
A. Ultimately, it is my opinion, based on what I read, for example, the reports of Dr. Sridhar, the radiation doctor, the chemotherapy doctor, ultimately the conclusion was, despite some missteps or misdirection from the earliest pathology reports, that the patient had lung cancer. The primary approach to this patient was that he had lung cancer. The final approach to the patient on the death certificate was that he had lung cancer.
So, I agree that there were questions, but, ultimately, I think that the doctors concluded correctly that the patient had lung cancer.
Q. And you realize Dr. Sridhar was still of the mixed view about this even after Mr. Allen passed away, wasn't he?
A. In what way? Explain to me what you mean.
What I saw again and again was Dr. Sridhar's comments,

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the patient had lung cancer.
Q. You don't believe Dr. Sridhar was ever of a mixed view about this?
A. On the contrary. I think all of the doctors, including the wonderful Dr. Sridhar, questioned the diagnosis.
I know that Dr. Sridhar signed the death certificate as lung cancer. I know because I have multiple references in the report of which you spoke that Dr. Sridhar described the

patient as having lung cancer, as did most of the other doctors.
Q. Now, when you were first retained in this case the attorneys sent you the medical files?
A. That's true.
Q. That's the ordinary way you get files in your office. They are sent in by the attorneys who retain you for the cases?
A. For a medical/legal case. For a medical case, I get them otherwise. For a medical/legal case, you are exactly right.
Q. You have people who work for you that help you with the process?
A. Absolutely.
Q. Including some college students?
A. We even hire college students as on a regular basis. Some are even ending up to go to law school. I don't know why not medical school.
Q. Well, we will get to that.

When we took your deposition that day, you didn't remember which of the records of Mr. Allen you personally reviewed, as opposed to somebody else in your staff reviewing them.
A. I said to you clearly there may have been pieces of paper I may not have seen with my own eyes, but I saw the complete text of those pieces of paper typed up into tables for me.
Q. Let me ask if you recall on page 62, line 21 --
A. Let me turn to it.
Q. Yes, sir.
A. I am there.
Q. You told us These college students sometimes review the medical records and pull things out, and there were secretaries that work for you who may type portions and all that?
A. Of course.
I didn't say at that time college students were the only ones we hire. I said in deposition we have respiratory therapists, nurses and other kinds of people who work on the staff.
Q. You have no written protocol from your staff about how they should review medical records, what they should look for, what they should pull out, how they should report?
A. No, there is no written protocol.
There is a very clear protocol based on teaching. I have got some senior people who teach the other people how to

extract medical records and do a lot of extraction themselves.
The people I work with, one is a nurse, also a respiratory therapist. She has worked with me for twenty years. I don't think she needs any written instructions. The other person is a respiratory therapist. These are my senior people. She has worked for me for ten years. She doesn't need any written instructions either. The younger people, the newer people work under those senior staff people.
Q. Let me ask you if this was your testimony:
"Question: Which medical records did you, personally, review?
"Answer: I don't recall."
Do you recall that testimony?
A. Absolutely, and my testimony is exactly the same today. I don't remember which pieces of paper I looked at, but elsewhere in my deposition I explained that I read verbatim the exact reports that had been typed for me and put into a table rather than looking through mountains of medical records.
Q. Isn't it also fair to say at the time you gave your

deposition, which is the time that you were under oath to disclose the opinions in this case and the bases for the opinions, you could not remember whether or not you had looked at the abdominal CT scans we were talking about?
A. That's true. I don't remember until today. I don't think I looked at it since either.

Q. You don't remember whether or not you reviewed the early scan, which would be the January CT Scan relating to Mr. Allen's kidney. You didn't recall that?
A. That would be the abdominal CT. I can't remember if I looked at that film.
I looked at the CT of the chest, which I described in my report, but not of the abdomen.
Q. By the way, do you know why the treating doctors asked to have CTs done not only of the chest, but of the other areas as well?
A. I know why they would have. I don't recall seeing where it was written, "we have gotten it because," but I testified before, and you are correct, it is routine to do a CT of the abdomen in a person who has lung cancer. It is virtually always done, maybe one hundred percent of the time, or close to.
In this case there was some initial confusion as to the pathology and it would have been appropriate to look at the kidneys structurally to see if there was an obvious tumor there, but whether the thinking was there might have been a kidney cancer or the thinking was "Let's just look at the abdomen for other sites of disease," either way, a CT of the abdomen would normally be obtained.
Q. Well, by the time you were deposed, you had read a fair amount about the case, some of the other expert disclosures and

so forth?
A. Sure.
Q. And you understood what the issues were?
A. Oh, yes.
Q. There was a conflict between whether this was a primary renal cell cancer or primary lung cancer?
A. I don't think there was a conflict, sir. I think the very initial pathology suggested that possibility. All the subsequent results and the enormous weight of the evidence is against it.
The doctors took care of the patient as lung cancer correctly. So, I don't think there was any controversy. But I do know there was an issue at first, and I do think it was exactly correct to get an MRI and CT of the abdomen, which was done.
Q. So, if someone said there were questions about this all along, you wouldn't agree with that, would you?
A. I think I have answered the question already.
Q. Meaning you would not agree with that. If someone said there were questions all along, you wouldn't agree with that?
A. I would say there were questions which were constantly answered because the doctors constantly dealt with the patient as a lung cancer.
I think they were correct to do so. Ultimately, the evidence proved them correct. But there was some mention of

renal cell carcinoma, absolutely.
Q. Let me go back and rephrase. I think maybe you misunderstood the question a minute ago.
At the time you were giving your deposition you

understood the issue being raised in litigation, the issue the jury would ultimately have to deal with, was whether or not it was renal cell primary or lung primary.
A. I think that's the issue the defense has raised, but never that of the doctors.
Certainly, I think the jury will decide based on the evidence. I understand that's what they are supposed to do, and I am here to say that the evidence is incontrovertible. It is extremely clear.
Most reasonable doctors, ninety plus percent of reasonable doctors faced with the evidence that I have seen would conclude the patient had a primary lung cancer.
Q. Going back to your deposition, and when you were looking, you told us that notwithstanding that you knew that issue had been raised in the case, at the time of your deposition you could not remember whether or not you had looked at the first CT Scan, and so my question is did you make any notes in all of your papers relating to what you looked at and what you observed at that time as you were looking at the CT Scan?
A. I certainly made notes pertaining to the films that I read and also I put into my report the interpretation of the CT of

the abdomen and the interpretation of the MRI of the abdomen obtained early on.
I do not recall looking at the CT of abdomen. I do know the CT of the abdomen was interpreted as not showing kidney disease and I do know the MRI of the abdomen obtained on 1/25 1999 was read as showing "The kidneys appear normal in size and configuration with no evidence of focal masses or hydronephrosis."
I do know it's in my report.
Q. My question was at the time you gave your deposition and you told the lawyers under oath what your opinions were, you didn't remember whether you looked at the CT of the abdomen and you didn't write it down and you couldn't remember.
A. You are exactly right as far as looking at the CT itself. I looked at the report on that particular date.
Q. You didn't think it was necessary to go behind the report and look at the actual CT Scan, although you did understand that was a major issue in the case?
A. I didn't think it was a major issue. I think it's a created issue. I think it is a fantasy, actually.
Q. A fantasy.
A. Well, there is proof it is a fantasy. The immunohistochemical staining, the X-rays, everything, but I thought, given the fact that the MRI and CT were both read by radiologists and I am not an abdominal radiologist, I thought

that was acceptable for me.
Q. Can you see this document?
A. I do.
Q. That was one of the early writings by Dr. Sridhar when he was evaluating this case?
A. I remember this note. In fact, I think I duplicated this note in my report.
Q. At that point in time he was considering the possibility of lung cancer on one hand and kidney cancer on the other hand, wasn't he?
A. He apparently was, apparently, because of the report which had been prepared on 1/22. This note is dated 1/25 1999.
On 1/22 1999 there was a pathology report suggesting renal cell carcinoma. So, I think Dr. Sridhar was working on that basis.

THE COURT: Mr. Reid, juror number six could not see the last document up there. Maybe others.
Am I correct? You were looking, trying to see. I know you wanted to see it, so I wanted to tell you about that.
MR. REID: I appreciate that.
(Publishing to the jury.)
THE COURT: The podium seemed to block it.
MR. REID: I will be careful with the next couple.
Is this microphone working?
THE COURT: I think so.

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MR. REID: It didn't seem to me to be.
THE COURT: Everybody hold their ears. When I do this, it usually really screeches.
Here we go.
BY MR. REID:
Q. Do you want to change any of your answers now that you can hear me?
A. I don't think I needed to hear you any better than I did. It remains a fantasy. But, go ahead.
Q. You could do this without any questions.
A. I know what questions you wish to ask me, sir, because you did it at deposition.
THE COURT: I am sorry we had that problem.
Mr. Yaffa or Mr. Cohen speaks in a more booming voice than Mr. Grossman or you. So, I probably turned it down just a little bit for them. I'm sorry it wasn't turned back up. That was just oversight on my part.
MR. REID: No problem.
THE COURT: Since I could hear you, I figured everybody could.
BY MR. REID:
Q. Now, I am looking at the report the final diagnosis dictated by Dr. Civantos. There was something in the record suggesting renal cell or kidney cancer.
A. I think you are talking about the addendum. That was

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actually prepared 1/22, I think.
Q. That was the first one. Right?
A. Let me see it again, because I don't remember exactly.
Q. That was in the record and that was causing the doctors to think about kidney cancer?
A. Yes.
Q. And the second is the addendum, which is one of the reports of Dr. Nadji on January 22nd, where he found that it was consistent with a renal primary?
A. That's what he said, yes.
Q. Okay.
And you disagree with that, of course?
A. It's not "of course".
I disagree with it because the evidence that Dr. Nadji presented -- I said this in my deposition very, very clearly -- the evidence that Dr. Nadji presented was actually against his diagnosis.
He said, Dr. Nadji, that what he found was consistent with -- which means part of that renal cell carcinoma is possible. "Consistent with" doesn't make a diagnosis -- he said that it was possible that the patient had a renal cell carcinoma.
He then presented evidence pertaining to immunohistochemical stains that were against the diagnosis of renal cell carcinoma.

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So, I agree that it is possible that the patient had renal cell carcinoma, but the evidence that he, himself, Nadji, stated, which was that the cells were positive for keratin and for EMA and negative, he said, for renal cell antigen, CEA and PSA, those things don't favor the diagnosis of renal cell carcinoma. They provide evidence against it.
Q. My question was actually a different question.
My question was simply do you disagree with Dr. Nadji? "Yes" or "No"?
A. Yes and no.
Let me just say, please, that I agree with him that finding clear cells by and of themselves is consistent with renal cell carcinoma, and I agree that renal cell carcinoma metastasizes to the bone. That I agree.
I disagree, because I know that one of the reports, one of the stains that he described, EMA, is much more evidence in favor of lung cancer than of kidney cancer, that the negative renal cell antigen represents evidence against kidney cancer.
So, I know that on the one hand renal cell carcinoma was possible. On the other hand, Dr. Nadji's own report showed that it was not likely to be the case.
Q. Looking at the same document, in fact, you told us you believe that when you read the report, Dr. Nadji virtually rules out kidney cancer. Didn't you tell us that?

A. If you would show me the exact page?
Q. Page 107.
A. 107?
Q. Yes, sir.
A. What I said exactly was in response to the question, renal cell, we are talking about renal cell carcinoma markers. He is talking about, or a specific renal cell marker, and you asked, or somebody asked me, rather, "So, the immunohistochemical staining that Nadji did does not support it, actually opposes the diagnosis of renal cell carcinoma" -- I said that.
Then the question was "But it doesn't rule it out. It simply suggests that."
I said "Weak, very weak, counselor. It virtually rules it out. It wouldn't be sufficient for my purposes to rule it out, but it is on the ropes."
That's what I said.
Q. You also later said "A reasonable person should not assume it was renal cell cancer based on this evidence"?
A. I went on --
Q. Is that what you said?
A. Well, let's just see what I said exactly. "That diagnosis is on the ropes, which is specific, not sensitive. But the specific antigen, not there renal cell antibody, an EMA, you know, is one hundred percent in adenocarcinoma,

twenty percent in renal. Keratin doesn't happen in renal cell carcinoma. So far it doesn't sell. If I am a reasonable person and present this to a reasonable jury, a reasonable person should not assume that it is renal cell carcinoma."
Q. And, Dr. Sridhar continued to have questions even after Mr. Allen passed away, whether the origin was kidney or lung, didn't he?
A. He signed the death certificate as renal cell -- excuse me -- as lung cancer, so I am not sure what you are basing his questions on.

But I think that doctors are supposed to question.
Q. I would like you to see the discharge summary of October 13th, 1999, page 1.
A. That would be the death summary.
Q. It is referred to as the discharge summary.
A. It is the same thing. In this case, it is the same thing.
Q. Several weeks after Mr. Allen passed away, two weeks?
A. October 1st.
Q. Dr. Sridhar wrote it was undecided whether it originated in the kidneys or in the lungs. Do you recall that?
A. I don't recall exactly those words, but I think it's true, that initially it was undecided.
Q. And --
A. And that the evidence piled up and piled up against it.

Q. This is a page from the hospital report, hospital records dated 8/28/99. Do you see that?
A. I do.
Q. And someone wrote there -- can you read number 1 under "Oncology"?
A. Yes. "Clear lung cancer versus renal with met."
Q. Somebody at that point was still raising the question whether it was renal or lung?
A. I am proud of them. I think they should have done it. Good for them. Let them treat patients like that all the time. Always questioning. It's the right thing.
Q. In this case if there had been an autopsy, we would know a lot more, wouldn't we?
A. I think we would know somewhat more, but I wouldn't have recommended an autopsy if I had been treating this patient, and I don't think in this case that an autopsy is necessary. But I agree that there would be certain things we would know more because we would have more tissue available for immunohistochemical staining.
Q. Doctor, in cases where there is no lung tissue available, which is like our case --
A. Yes, and many cases.
Q. -- isn't it true that you do advise routinely autopsies be performed in those cases?
A. In a medical/legal case, yes. I don't think this case was

known to be a medical/legal case at the time of the demise of the patient. Nor do I think that the doctors taking care of the patient were thinking about that.
Q. Doctor, let's go back and talk about a couple of the topics that were raised this morning by counsel's questions.
You told us that you were educated in Canada.
A. Yes.
Q. And you came to the United States in about 1982?
A. Correct.
Q. And that was a couple of years after, you completed your residency?
A. True.
Q. And you came, in part, because you didn't like socialized medicine?
A. Oh, that's absolutely true, and what it was doing to my patients.
Q. And the other reason is you really just wanted to make more money?
A. That's true, and the fact my family had already moved here or, actually, my wife's family had moved here.
I don't know if you saw my elderly parents here this morning. I think you asked -- somebody asked me. They have an

apartment here. It was a very nice move, from a family point of view.
Q. And shortly after you arrived in Miami, you wrote something

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in the Dade County Medical Association Journal that American doctors make about four times what Canadian doctors make?
A. That's true, and I think it's more than that now.
Q. And you mentioned today you had failed one test?
A. I had.
Q. That was actually the pulmonary, the board exam for pulmonary medicine in Canada before you came to the United States?
A. I passed the Quebec and the American. I failed one out of a zillion tests that I took, yes.
I am sort of proud of it. It's just a long process of taking many, many examinations, and I wasn't perfect, but I was pretty close.
Q. You are proud about a lot of things, aren't you?
A. I am. I really am. I am proud of what I was able to accomplish at South Miami Hospital as a pulmonary doctor in twenty years, and I think a lot of people know about that, too. My family is proud of it, too.
Q. The first time that you testified in a case involving tobacco was in 1996?
A. In court?
Q. Yes, sir.
A. In deposition before that, and, actually, do you mean a tobacco case where the defendant was a tobacco company?
Q. Yes, sir.

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A. Because I testified about tobacco.
Q. Sure.
A. For twenty-odd years.
Q. In your asbestos cases.
A. In cases involving not just asbestos, but many other things.
Q. We will get to those.
A. But tobacco, yes, I testified in the Carter verus Brown & Williamson case, a famous case in Jacksonville, Florida in 1996.
Q. And as of the time of that case, you had never published anything about smoking or lung cancer in any peer review journals. Is that fair to say?
A. That's true.
Q. And still haven't?
A. Correct.
Q. And at that point, you had never published anything about, really, any aspect of health and smoking in a peer review journal?
A. That's true.
My research was all computer-oriented. I wrote about a dozen or ten computer programs, some of which were published, some of which were sold, but I was not an academic. I never was and I -- I don't work at a university and I don't publish medical journal articles.

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I have written a book. I am collaborating on another book, and I have done a lot of literature research, but not published research.
Q. Now, you have not done any, any peer review articles in the general field of pulmonology?
A. That's what I said. I never was an academic, never did publish a series of papers in the scientific literature.

Other people do it, and I depends on that kind of work, use it, study it, apply it and provide guidance and leadership in the hospital based on it.
Q. Up until the time you had testified in the first tobacco trial, you had never done any original scientific research about any area of cancer causation?
A. That's absolutely correct. I have been a clinician, not an academic or molecular biologist. I was never a molecular biologist.
Q. It's fair to say you weren't an academic, you said?
A. Yes.
Q. And you weren't a writer or researcher?
A. That's true. I have written some, but not for medical journal articles. You are right.
Q. And you don't give, you don't present papers to academic conferences and those kinds of activities?
A. I do. I mean, I am presenting a paper to an academic conference for the judiciary on Friday. I am going to Indiana.

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I have been asked to make an academic medical/legal presentation to a judicial conference in Indianapolis.
The nexus, the cross between medicine and law, I do a lot of lecturing on that. I have lectured at the Department of Justice in Washington, D.C., but I don't do papers, say, at the American College of Chest Physicians meetings, that I haven't done.
Q. You have lectured to lawyers a number of times about suing tobacco companies?
A. Oh, yes, lectured to lawyers and doctors and people who come and, as I said, for example, to the Department of Justice in Washington, to a whole group of lawyers who work for the United States Government involved in litigation against the tobacco industry. But in public and in private meetings, I have done that, exactly.
Q. In fact, you were just on a conference of lawyers who represent plaintiffs who were planning to or, in fact, have sued cigarette companies out in San Francisco?
A. TPLP, Tobacco Products Litigation Project, and there were doctors there, scientists, but mostly lawyers.
Q. Doctors who hope to be retained by lawyers who are suing tobacco companies in cases such as this?
A. I don't know if they hope to be retained. I am not sure it's such a great pleasure, but I don't know if they hope to be, but some of them had been retained or would be retained or

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was somebody serving as a resource for information.
Q. Some of the writing you do is actually to write questions you should be asking in litigation?
A. Right, or that you should be asking.
As I said, I can expect questions that you should ask me and the plaintiff's attorney should ask me.
Q. Now, you began working in the medical/legal cases shortly after you arrived in the United States?
A. True, although I had done some in Canada as well.
Q. You began working with Mr. Wilner. That was the first attorney with whom you worked in the United States?
A. I think I first worked with Mrs. Cole, Susan Cole here in Miami.
Mr. Norwood Wilner of the Spor, Winter firm in Jacksonville. I think I started to work with him a year later. It is twenty-odd years ago.
Q. Mr. Wilner retained you to review files and come into court and testify against injured parties in suits brought against

asbestos manufacturers. Is that right?
A. I wouldn't describe them as that at all. I think that's a false description of what it was that I did.
I was retained to review, as it turns out by now, thousands, actually more than 10,000, probably approaching 15,000 individual patients who were involved in litigation against asbestos manufacturers and various other things, a very

large number of those patients, a huge percentage.
I testified or reported their disease was caused by asbestos. A very significant number of those people, their disease was caused only by smoking. A very large percentage of those people had their disease caused by both smoking and asbestos exposure, and what I was retained to do, not just by Wilner, but by, probably, at this point one hundred different companies -- and by the Coast Guard and by other agencies -- I was retained to review patients' cases and determine if their disease had been caused by asbestos or smoking or something else.
Q. And you were retained not by the lawyer, but by the asbestos manufacturers to do this. That's who paid your fee. Correct?
A. Almost always I was retained by asbestos plaintiffs' attorneys also. But that's the minority.
The great majority were by attorneys who were representing either manufacturers or a company who had been using asbestos manufactured by somebody else.
Q. And you have actually represented something over forty-five different asbestos companies and doing this kind of work?
A. I don't represent anybody. Retained by. I think it's more than forty-five, and by this point it's probably one hundred.
Q. You told us it's 15,000 cases?
A. I think by now, over twenty years, it's probably

approaching 15,000. I think we are now up to about 600 or 700 cases a year.
Q. The same asbestos companies paid you to go around and give lectures to their lawyers about how to defend the asbestos companies in these cases?
A. Again, I think your characterization is disrespectful, but --
THE COURT: You expected --
THE WITNESS: Expected better.
THE COURT: You expected compliments?
Let's let Mr. Reid ask the next question.
Let's move on.
BY MR. REID:
Q. You were in the middle of an answer.
A. I was going to say I think the real thing is some attorneys, some firms retained me to make presentations in certain cities, just like the court in Indiana is retaining me to make a presentation about asbestos.
That is not a firm, per se. It is something called a Docket Management Committee for Friday.
I am going to be going and lecturing to Judges on Friday in Indianapolis. That is not a firm that is doing this -- although I was invited to do it by a firm -- nor by a client or manufacturer of asbestos.
I certainly have met with attorneys who represent

asbestos defendants. Some of them have nothing to do with asbestos, or very little to do with asbestos. I have met with such people and given them educational lectures, yes.

Q. You have given a lot of depositions, haven't you?
A. I have. I have given -- you mean, in my life or some period of time? I have probably given something like two hundred depositions in my life.
Q. Now, if you go back to the question I asked, my question was whether or not you have been paid by asbestos companies to give lectures to attorneys about medical aspects of defending asbestos cases.
I want to ask you if you remember testifying in a case called Anderson versus several tobacco companies.
A. I sure do.
Q. Page 1865, let me ask you if this was your testimony:
"Much like you have done with the plaintiffs' lawyers in the cigarette cases, you lectured defense lawyers in the asbestos cases, didn't you?
"Answer: Still do.
"Question: Companies have hired you to speak to their lawyers about asbestos litigation, haven't they?
"Answer: Oh, yes."
A. Oh, yes. That's not what you said. That's not what your question was.
You asked me if companies asked me to lecture and

prepare them for or, rather, lecture about asbestos matters. There I was talking about attorneys who were asking me to.
The difference is fine, but important. I don't recall being asked ever by a company like, let's say, Westinghouse to lecture to lawyers. It has usually been by their attorneys.
Q. And --
A. I have certainly done that. I have done it for other entities in addition to attorneys for asbestos companies.
Q. And you have also said that you were the only pulmonologist in Miami or Broward County who sees patients on behalf of the defense for asbestos litigation?
A. That is generally true, yes.
Q. And you said that you have a complete monopoly in South Florida on seeing patients in asbestos litigation?
A. I think that's generally true, yes.
Q. And that's more so even today than several years ago?
A. I think some other people see patients who have been exposed to asbestos on occasion, but probably ninety-nine percent of the cases are seen by me.
Q. Now it has expanded even beyond Miami that you are doing the same type of activity?
A. I wouldn't say "now". I would say for years.
I have been retained by all kinds of different entities, mostly attorneys, but not only, from coast to coast, and I have done medical/legal work. I have given testimony,

depositions, prepared reports, did projects, special projects for all kinds of cases, not just asbestos. You are speaking so far about asbestos.
Q. Yes, sir.
A. I have done all kinds of other things, too, in the medical/legal arena, certainly not in every state, but in a large number of states in the United States.
Q. Now, you mentioned your patients several times today.
A. Yes.
Q. You mentioned these asbestos patients.
A. It's different.
Q. That you looked at?
A. That's different. When I speak of my patients, I mean clinical cases.

Q. I understand. You have also referred to these asbestos plaintiffs as patients?
A. Sometimes they are. They have come to my office and I have examined them. In some cases I actually traveled to other cities and examined other people.
Q. The vast majority of these patients are people referred to you by asbestos company lawyers?
A. If you wish to stick to asbestos, you are right.
Q. About ninety percent, in fact?
A. I think it's more than that, with the exception of people like those who are sent to me by the Coast Guard on a regular

basis, and some other agencies. I am not sure exactly which ones.
Q. You are, essentially, hired by the lawyers to testify that their asbestos company clients are not responsible for the injuries to these people that you have talked about?
A. That's false. That's an obvious misrepresentation.
I am retained to evaluate cases. If the patient's disease is caused by asbestos, that is exactly what I say. If it is caused by something else that has nothing to do with asbestos, that's exactly what I say.
If it is caused by a combination of asbestos and other things, that is exactly what I say, and I am retained not to testify against people, although I certainly have testified against the plaintiffs in a sense, that my testimony, the evidence that I gave and the testimony opinion didn't benefit them, but I have been retained to review cases and give an expert opinion.
Q. And it's fair to say in those cases your job for your asbestos company clients was to blame something else besides asbestos for the injury of those folks?
A. No, that's not fair to say.
Q. Okay.
A. I think, again, your suggestion is that what's happening is that I get hired and paid money to lie, to misrepresent, to make statements that are false, and, actually, there is nothing

that would get me to do that.
So, your implication is understood by me and probably by the jury, and I will tell you that there is nothing in this world that would get me -- certainly not money -- that would get me to testify that a person's disease was not caused by asbestos when it was, in fact, caused by asbestos, because what I do every single time is consider what caused the disease, not just in medical/legal cases, but in clinical cases.
And whatever caused the disease, that is the truth I speak and nothing will get me to vary from that.
Q. You actually published a book along with a lawyer, Mr. Wilner, called Asbestos Medicine on Trial?
A. Yes.
Q. And originally it was called Asbestos Defense, I think?
A. I never called it that. I think the publisher wanted to call it that and we said "Absolutely not."
But the name of the book is Asbestos Medicine on Trial, A Medical/Legal Outline.
Q. It does not appear in a journal. It is just a guide book for folks handling these kinds of cases?
A. That's not what it is.
It is a medical/legal text. It is not peer review. You are right. It is based on a huge body of peer reviewed literature which I analyzed and present in an organized fashion, and the book was written for attorneys, doctors,

insurance people and Judges.
Q. And there are twenty-seven pages of model questions and answers for asbestos expert witnesses in this book?
A. There are, indeed.
Q. And you have said in this book -- let's see if I can find it.
You have a section on purchased diagnoses?
A. Correct.
I have spoken against people who seem to make a diagnosis based on economic interest, that somebody comes, pays them and they make the diagnosis somebody wants.
Q. You talk about doctors who make good money diagnosing asbestos clients?
A. True. There are such people. Some of them are totally legitimate and honest people. Some of them have, I think, been biased by financial considerations.
I have lectured wildly against bias. I have repeatedly lectured and written in favor of participating in the legal system in an absolutely honest and aboveboard manner, because the issues of asbestos medicine are so complicated and the jury needs a doctor, an expert to explain them.
Q. You have described a class of physicians has arisen that, more or less, specializes in medical/legal referrals?
A. Correct.
Q. You state "At the least, many physicians depend upon these

referrals for a sizable fraction of their gross"?
A. That's true. In fact, it is increasingly true.
Q. You say "The pressure exists to return a considerable number of favorable diagnoses"?
A. That's correct. That's what I won't do myself, and I warn readers not to be influenced to give a diagnosis that benefits the person paying their bill.
I won't do that and certainly didn't do this in this case.
Q. You certainly made good money diagnosing asbestos claims?
A. I have made considerable money doing all kinds of things, sir. I have made considerable money in a wide variety of medical/legal endeavors.
I have made money from selling computer programs. I have a computer software company, which I own. I have made money, I have lost money in the stock market. I have made money in all kinds of things.
Q. You are also engaged in medical/legal referrals?
A. Absolutely.
Q. You brought cases to Mr. Wilner, for instance?
A. I don't do that very much. I have done it a couple of times. I have done it a few times to asbestos plaintiffs' attorneys also like my friend, Mr. David Lipman, who works here in Miami. Although he has cross-examined me, as you have, and although he has been against my position, typically I have

referred cases to him when I thought patients had disease caused by asbestos. But that's not much of what I do. Much more is to me, rather than from me.
Q. Now, in the early '90s, the level of asbestos litigation diminished. Is that fair to say?
A. Temporarily. For a short period of time, it did diminish.
Q. That's because of bankruptcy of some of the large asbestos companies?
A. Primarily, I think so, yes.
Q. That led you and Mr. Wilner to begin to look for another

source of income where you could do the same type of activity?
A. In other words, my motivation was to simply maintain my income stream. Is that what you are suggesting?
Q. My question is was that a reason for you and Mr. Wilner to look for other areas in which to work besides asbestos because asbestos was slowing down?
A. That's certainly true. I certainly have developed expertise in silicosis. I do very little malpractice. Don't like it very much.

Certainly in the nexus the cross between medicine and law, I have done a wide variety of things. If there was less asbestos, I would do other things as well, sure.
Q. That led the two of you to begin to develop the concept of suing tobacco companies?
A. No, that's not correct.

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The reason that arose is Wilner came to me and said the real culprit in a very large percentage of asbestos cases is not sitting in in the courtroom. The real culprit is the tobacco company.

"I think that the tobacco industry should be sued." That's what he said to me.

I said to him I didn't think it was possible, given past history, but he asked me to review the literature. I did, and I then became convinced of the legitimacy of the project, at which point I started to work with him about it.
Q. In fact, you developed the concept for Mr. Wilner of suing tobacco companies?
A. I developed some of the scientific bases, absolutely correct. Mr. Wilner developed some of the legal bases. I don't suggest I am an attorney. I know a little bit about the law, but I certainly didn't develop any of the legal aspect of that.
Q. Let me ask you if you remember the testimony in Henley. Do you remember that case?
A. I sure do, in California.
Q. "And you consulted with him, meaning Mr. Wilner, and testified in cases in which he represented the plaintiffs. Right?

"Answer: I did that more and more. I think I actually developed the concept with him.

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"Question: Of suing cigarette companies.

"Answer: Correct".
A. Yes, I stand by that. I did the medical. He did the legal. We went to the jury in Carter in Jacksonville, which was the first win against the tobacco industry in the modern era.

MR. REID: Your Honor, I move to strike that. It is irrelevant.

THE COURT: Other than showing or getting into biases and bias and/or prejudice, the last half-hour has been of the same vein. We have explored what the witness does in the stock market and everything else.

I don't know where I would begin to strike the irrelevance.

Ladies and gentlemen, counsel is entitled to, of course, demonstrate anybody's personal interest or bias or prejudice. He has a right to do that. I am not being critical of Mr. Reid or any of these lawyers when they do that. But a lot of this has very little to do with -- and I think Mr. Reid, I think they would all agree with this -- it had little to do with what was the cause of the cancer.

The question is whether or not what the experts have offered as being the cause of Mr. Allen's cancer is buttressed by sound medical opinion or not, and you, folks, have to decide that.

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So, to that extent the last half-hour or so is relevant and admissible, but I would kind of hope that we were winding toward the end of it, if you can, Mr. Reid.

I am not trying to limit you. You have a right to go into this. I think I have made that clear to everybody. I think we are wandering far afield when we get into what Mr. Wilner said to Dr. Feingold and what Dr. Feingold said to Mr. Wilner in California, except as to bias or prejudice.

MR. REID: Your Honor, could we take a short break so I could reorganize?

THE COURT: Certainly. I have no difficulty at all.

Would you step out, ladies and gentlemen, and, doctor, would you kindly wait in the lobby?

Thank you.

[The jury leaves the courtroom at 4:26 p.m.]

[The witness was excused at 4:26 p.m.]

THE COURT: All right. Let me go over this with counsel. I hope I did not say anything that was inappropriate to the jury. Frankly, I think they have been looking mystified a little bit.

What these people talked about in other cases or that sort of thing, what he got on the stock market, he has made money and lost money, well, what difference does that make to your average juror?

Well, he volunteered that. You didn't ask him. He is

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doing a lot of volunteering you are not asking, and you can't control that, of course.

Once you ask the question, he is going to answer it however he wishes to. He is obviously very, very experienced in giving testimony in depositions and trials, and I hope I have not been unfair to any lawyer in this case in what I just told the jury, but I was hopeful that I could get the witness and everybody to focus a little bit back on the issues, and I really think you clearly demonstrated the witness' interest and where he is, what his background is, where he is coming from, if you please, in at least some of his testimony.

On the other side, balanced against that, I think plaintiffs have every right to rely on his very positive statements. None of this has changed his opinion, the cancer was caused by the lung disease.

I know there is more latitude in civil than criminal matters but, boy, we are going way -- by the way, here is another thing: This is mainly what I wanted to tell you. I did not have the faintest idea in the world this witness had any, any connection with Woody Wilner, who I may have -- I don't know whether you all know this. He was a law clerk of mine. He was with me for a year. I probably have said that. You did not know that?

MR. REID: (Shook head.)

THE COURT: I thought back in November or so we were

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talking about lawyers who appeared before me and I had read something about the -- I keep calling it the Brown case. It is not. It's Carter, the Jacksonville case.

MR. REILLY: Carter versus Brown & Williamson, Your Honor.

THE COURT: Woody Wilner twenty years or so ago, when

he came out of Yale and the University of Florida Law School, applied and was selected, was a law clerk in my office here in the court. He was with me for a year.

Now, having said that, the only thing I know about the Carter case is reading in the paper something and his name showed up when it happened, whenever that was, five or six years ago.

I have not seen him, you know, in whatever it is, five or six years, longer. I don't know anything about his practice. I never practiced in Jacksonville and I know he was involved in asbestos litigation with Susan Cole, who came over here every day for three or four years, or whatever it was, and Woody Wilner appeared in one of those cases, now that we are talking about Susan Cole.

In any event, I think every lawyer in this town has been before me, you know, at one time or another, except Mr. Reilly, and he is making up for it in spades.

All right. Well, I hope -- if I did anything, if I said something that you want me to correct -- I was trying to

balance this thing and let the jury know what we were doing. I probably shouldn't have, but I did.

Is there any curative instruction you want me to state?

MR. REID: There is nothing you can state. It would be easier if the witness would say "Yes" or "No," and we would move on.

He said "Yes" or "No" many times before and today he decided to argue about things.

THE COURT: I know Mr. Grossman is just about to tell me when you ask a question, you have to live with the answer. I am guessing. I don't know what he is going to say. That's what you would say if you were standing up.

Mr. Grossman, is that -- you are standing there. You have a right to say whatever you wish.

Go ahead.

MR. GROSSMAN: I don't want to say anything.

THE COURT: I thought you were approaching the microphone there.

MR. GROSSMAN: It's just an ugly habit.

THE COURT: Okay.

MR. GROSSMAN: Judge, I do at some point want to advise the Court of a scheduling situation, but I don't mean to interrupt to take the jury's time now. So, you let us know when to announce it.

THE COURT: Well, then, I didn't give you -- you need a couple of minutes or something to look over your notes?

MR. REID: Yes.

THE COURT: Fine.

If that is a problem, I don't know what we will do about it now. I didn't have a clue.

MR. REILLY: It's not a problem, Your Honor.

THE COURT: I didn't have any idea this man had ever met one of my former law clerks, didn't know it until he started talking about it just now, and I am amazed to find out there is a book or a pamphlet, or whatever that thing was, amazed to learn that.

It just shows if you live long enough and you are in litigation in South Florida long enough or in or around it, you are going to get to know everybody sooner or later, or at least see them.

All right. Let's take a five minute recess.

[There was a short recess at 4:32 p.m.]
THE COURT: My apologies, but I had a phone call from a marvelous lawyer old friend of mine from Tampa who is on the ABA Nominating Commission calling about -- that's not why I would take time to talk to somebody -- but dealing with a young woman named Cecilia Altonaga, who has been nominated by our President to be on our Court.
(Discussion off the record).

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MR. REILLY: Judge, as a matter of scheduling, I asked Mr. Reid how long he had, and I know how long we have, and we have a new topic to take up with Your Honor. I don't know whether or not it is a good time to break for the evening and take up an issue that will come with a witness that is going to come tomorrow.
THE COURT: As I indicated to you, normally we go to 5:30 or 6:00. I was hopeful we could finish with the witness. I will stay here with you all night to take up whatever legal arguments you have got and we can let the jury go after that.
MR. COHEN: Your Honor, I was hoping we could conclude and finish with Dr. Feingold today.
THE COURT: That's what I am hoping. If we can, we can. If we can't, we can't. I was hoping we could.
Then we could take up any legal arguments with upcoming witnesses after the jury is excused and the doctor is gone. Let's see if we can finish it up.
To that extent, doctor, I will ask you to keep your answers shorter, if you will, please, and if there is something that needs clarifying after Mr. Reid is finished, I am sure Mr. Cohen or Mr. Yaffa will bring it up on redirect.
[The jury enters the courtroom at 4:56 p.m.]
THE COURT: Thank you. Be seated, please.
All right, Mr. Reid.
BY MR. REID:

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Q. Dr. Feingold, I want to show you one other document. You and Mr. Wilner prepared, in much the same way you prepared the asbestos document, you have now prepared a pamphlet or a book called The Medical/Legal Update on Cigarette Smoke.
Is that right?
A. I did this one in 1995. I think there are several versions since that time.
Q. And that was sent, that book was sent to doctors throughout the State of Florida with a letter from you and Mr. Wilner?
A. Correct.
Q. Urging that doctors refer patients to Mr. Wilner if they had legal claims?
A. Exactly consistent with the call by the American Medical Association to take whatever means possible to combat the tobacco industry.
MR. REID: Move to strike the last portion.
MR. GROSSMAN: Based upon what? That's his explanation.
THE COURT: I'm sorry. Denied.
BY MR. REID:
Q. And the letter did not mention you might be an expert witness in the case if Mr. Wilner was retained by those folks?
A. I don't remember.
Q. And you and Mr. Wilner have sponsored conferences, hosted seminars to which only lawyers who were plaintiffs in cigarette

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cases were invited. Is that correct?
A. Correct.

Q. And you put on these training programs about once a year?
A. I have put on some at South Miami hospital and I have attended others where I have spoken.
Q. And one of the purposes was to obtain additional consulting work for you. Is that fair to say?
A. I suppose at some level. I don't really think that's the purpose of it. It would be a consequence, yes.
Q. And Mr. Wilner holds conferences in which you are allowed or invited to speak?
A. He is sometimes the chairman. He is sometimes present. That's true. I speak at national conferences maybe once a month.
Q. And Mr. Wilner formed the National Tobacco Trial Lawyers Association and you spoke at the first meeting. Is that fair to say?
A. I think I did, yes. I have spoken at some of the meetings since then as well.
Q. And you have described yourself, haven't you, as the single most sought after witness in the United States?
A. I think that's hardly humble. I am not sure what context that was in.
Q. And you believe that that is attributable to your doing a good job in your work and you are proud of it?

A. In terms of medical/legal work and pulmonary medicine, I am well-known. I have done a lot of that nationally and internationally, yes.
Q. In fact, you consider yourself, and you so testified under oath, to be a world famous expert witness?
A. Again, I am not sure what context. You will have to read the whole sentence or paragraph. I don't think I just came out and blurted that out.
Q. And your income has continued to grow, you have testified, as you have become more famous, frankly, all over the world?
A. True. That's absolutely true.
Q. And in the last ten years you have earned about $6 million doing what you are doing here today?
A. I am not sure at this point. It's hard to know because all of the money that comes in to the Department of Forensic Pulmonary Medicine is billed under my name, but pays for a whole department in the hospital.
Certainly, we bill roughly 1.8 or $1.7 million for all medical/legal activities for the hospital department, but that pays for a whole group of people and facilities and so on.
I get a substantial amount of the money, but so do a lot the of the other people.
Q. In fact, you have also earned about $8 million doing this over the last twenty years?
A. Medical/legal work or all kinds?

Q. Medical/legal.
A. Of all kinds, over twenty years, I think it's at least that. I am not sure exactly what it is.
Q. Today, ninety percent of your earned income comes from litigation, doesn't it?
A. I think so. Probably. I do a lot of medical work for patients for free, pro bono or no charge.
I see a lot of patients for nothing or very little money and I do make more money in medical/legal work, yes.
Q. You talked a little bit about what you charged for the work you have done in this case. Did you say this department that you -- I think you called it the Forensic Pulmonary Medicine Group?

A. There is a division of pulmonary medicine and in its structure, according to South Miami Hospital, there is several departments. One is forensic pulmonary medicine. One is a sleep lab. He mentioned the pulmonary function lab.
Q. The litigation is done through that department?
A. Correct.
Q. The 6 or $8 million is through that department?
A. Correct. That's not exactly right. The department hasn't existed for that long.
I made money before the department existed.
Q. Sure.
A. But currently all the money is billed by that department,

yes.
Q. You have --
A. It's actually billed under my name, though.
Q. You have a staff of three or four regular employees who are not medical doctors. Is that right?
A. The staff is increasing right now we have increased since my deposition.
Q. Okay.
A. Right now we have, we have fifty-five full-time and multiple part-time.
Q. Then you have college students, you told us about?
A. Yes.
Q. And a bookkeeper?
A. I included her as full-time.
Q. In this case you were asked questions about what you charge.
A. Yes.
Q. This is the report that you prepared, a 109 page report in this case?
A. There are two reports in this case. One is an expert witness disclosure. I think in your hands is the expert witness disclosure, and separate from that, not included in that, is the case specific patient report dated August 30th, 2002.
Q. And the case specific was about a page and a half?

A. No, the case specific is thirty-five pages.
Q. Okay.
This report that I am holding, it starts with your picture on the third page. That's your report that you filed also in this case?
A. It's an, what's called an expert witness disclosure. It's about one hundred pages.
Q. It has nothing directly to do with Mr. Allen?
A. Correct.
Well, it has nothing to do with the specifics of his case, but it is a lot to do about cigarette smoking and lung cancer.
Q. This is a report you use in cigarette cases in general?
A. It is the ongoing and ever-changing expert witness disclosure in tobacco cases, but the thirty-five page report I issued pertaining to this patient is the case specific report.
Q. And this was, this report is the combined work product of Mr. Wilner, the lawyer, and you?
A. Originally when I prepared it before the Department of Justice presentation, yes. But since then, I have changed it multiple times since. There were certainly legal aspects directed by Mr. Wilner, the medical by me, and at this point it's almost all my work.
Q. And you both have a copy, you and Mr. Wilner both have a

copy of this or a report on your respective computers?

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A. Right, but I don't think he would have the recent copy. I think the last copy he has is probably a few years old and there are multiple new versions since then.
Q. You have not filed an expert disclosure in a case in which Mr. Wilner was the lawyer in how many years?
A. You know what? He was involved, but the last case I did in Philadelphia Katy Carter, he was not the lawyer. I don't remember the last case he, himself, represented the client.
Q. When you and Mr. Wilner were consulting on getting this document together --
A. Originally we are talking five or six years ago or more. It would have been -- the first version of that document would be about '96 or '97.
Q. And when you were working together, you both had it on your computers. You were comfortable with whatever changes he might make to the document?
A. He didn't do them independently. He and I would talk. We would e-mail back and forth. We would look at various things together.
Q. You testified you would depend on him to check what you said on scientific issues?
A. Absolutely. Mr. Wilner is an engineer. He has an incredible amount of scientific knowledge and background in math and other issues. He certainly did check some of the science I wrote. I actually checked some of the law he wrote.

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You know, that was a collaboration.
Q. In looking through the report, you cannot identify which part you may have written originally, which part he may have written originally?
A. Some of the things, I can't. It's hard to dissect it.
Q. You filed this with your affidavit saying these increase your opinions and they are filed in court, and you have done that as long as you have had such a document?
A. Sure, absolutely.
Q. Earlier versions and this version?
A. Correct.
This version is much more purely my work, but to the extent Mr. Wilner had scientific or legal input, I recognize that the opinions that I state in that report are my opinions.
Q. Now, I want to ask you one question about the report.
A. You are talking about the expert witness disclosure, not the case specific?
Q. Yes, sir, the disclosure, about your fees.
A. Okay.
Q. Do you remember the page? I had a note on it. I lost the note. Do you know which page?
A. There was a page at the very end about expert witness fees.
Q. Yes, sir.
A. But I don't know what the date is of the document you got and the fees were increased.

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THE COURT: Gentlemen, you all have for sometime been cutting each other off and it's --
MR. REID: I apologize.
THE COURT: -- it's very difficult for her to get it down. Let him finish his question and let the witness finish his answer.
BY MR. REID:
Q. Is this the one you filed in this case? I assume the fees apply to this case?

A. Not necessarily. The fees may have been raised since that was produced.
If I may ask you, what was the date of that report? It should be either on the front or on a footer.
Q. You did -- oh, the 30th of August.
A. 2002?
Q. Yes.
A. I think the fees were increased since then.
Q. Today you told counsel it was $5,000 to work up a case?
A. You know, I am not exactly sure. I think it's $5,000 or $6,000, yes.
Q. Yes, sir.
In August, it was actually $6,000.
A. I think it may have been 6, and maybe 5. I actually don't set the rates exactly. It's about that. It's five or six.
Q. You say it has gone up since then?

A. It's more than six for the preparation of the case. It may be less. As far as the pre-deposition preparation, it is 5 or $6,000.
As far as courtroom testimony, it's $500 an hour. I think the courtroom testimony was increased by the staff and I think the prep may have been decreased.
Q. In this case you were deposed for a limit of four hours. Do you recall that?
A. Not exactly. I don't know.
Q. For those four hours you charged $4,000 for that deposition. Do you recall that?
A. No, I don't. If the deposition was scheduled for a day, then there was probably a $4,000 day charge.
Q. You were scheduled for four hours and your charge was $4,000.
A. Don't know. Didn't do it. If you have the bill --
Q. That would be $1,000 an hour for deposition?
A. I think that was the charge for the whole day. I think the staff must have scheduled a whole day for a reason.
MR. REID: That's all I have.
Thank you.
THE COURT: Mr. Reilly, since you have a tremendous inclination in cutting off witnesses and they cut you off, I will ask you, facetiously, because Mr. Reilly is very conscientious, for the reporter to get it down. That is what I

am trying to do.
All right.

CROSS EXAMINATION

BY MR. REILLY:
Q. Good afternoon, doctor.
A. Hi. How are you?
Q. I just want to talk to you about two topics. Earlier today you talked about Dr. Nadji and his pathology, immunohistochemical staining.
Do you remember that?
A. I do.
Q. You indicated that the stains he performed and the results he received should have led him away from a diagnosis of renal cell cancer. Correct?
A. Correct. Or I said they didn't support it, or something to that effect, yes.
Q. I am not --
A. I don't remember the exact words, but you are right.
Q. Now, I just wanted to run through the tests he performed --
A. He performed. Right.

Q. The tests he performed, the results he got and why you think they are inconsistent with a renal cell carcinoma.
A. Okay.
Q. Before you start, let me just put your name up here.
So, now what tests did he perform?

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A. Several. He did keratin, to begin with, k-e-r-a-t-i-n.
Q. Okay.
I think you said he did an EMA?
A. Epithelial membrane antigen.
Q. If you don't mind, I will make it EMA. It's a lot easier for me and the court reporter.
A. It is very important, actually. It is a membrane antigen of epithelial cancers, cancers in the lung. But, go ahead, EMA.
Q. He did a PSA?
A. He did.
Q. He did a CEA?
A. Yes.
Q. He did an RCA?
A. Which stands for -- well, now, I wouldn't call it RCA. Renal cell antigen.
Q. Sounded like RCA to me. Renal cell antigen.
A. If you just put alphabetical representation, it isn't clear. It's actually a kidney antigen. It's a renal cell antigen.
Q. I am going to abbreviate it here. I think everybody will understand exactly how this all turns out.
A. I hope so. He did something else as well.
Q. Pardon me?
A. He did something else as well.

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Q. What else?
A. A Her-2/Neu.
Q. That comes much farther down the road. Right?
A. A couple of months later. H-e-r-2/n-e-u.
Q. Do it for me one more time. H-e-r --
A. H-e-r-2/N-e-u. That is the representation of it. I won't tell you what that says.
Q. Now, his result on the keratin was positive or negative?
A. It was positive. There is a problem, though. He didn't identify which keratin.
Q. His result on the -- I am standing in front of people. I'm sorry.
A. EMA.
Q. His result on the EMA?
A. Was positive.
Q. His result on the PSA was?
A. Negative.
Q. His result on the CEA?
A. Negative. Incorrectly, but negative.
Q. His result on the RCA was?
A. Negative.
Q. His result on the Her-2/Neu?
A. Negative.
Q. All right.
Let me go back for just a moment to the keratin. A

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positive keratin in this case, was that of any significance in your interpretation of the results of this test in terms of whether this was a renal cell carcinoma or not?
A. Well, when the keratin was eventually identified, yes, because high molecular weight keratin is typically positive in

lung cancer, negative in kidney cancer. CK-7, cytokeratin, in this case was extremely positive.

It is virtually never one hundred percent that positive in kidney cancer. I think it's impossible. When the keratins are identified, he didn't identify them as to which type of keratin, a high molecular weight keratin or CK-7. The positive results are useful. Just to say "keratin" doesn't help very much.

Q. Your interpretation of a positive keratin as performed by Dr. Nadji says lung cancer, not kidney cancer. Right?

A. Not exactly.

As I said in my deposition, it isn't appropriately defined. I don't know which keratin he is talking about if it is just a polyglot of keratin.

When you look at the keratins as they should have been defined, as they were eventually defined, as high molecular weight keratin or CK-7, those things are almost only positive in lung cancer and never positive in kidney cancer. Then I know finding a positive is evidence against kidney cancer and would have been a negative, would have been evidence against

lung cancer, and I know Nadji knows this.

If Nadji had known if the keratin was positive, not negative, he should have inquired in his own mind which keratin. If it is high molecular weight keratin, that's lung. If it is CK-7 positive, that's lung and can't be kidney.

Q. So, how did you interpret -- is a positive keratin as reported by Dr. Nadji pro-lung cancer or --

A. Within the limitation of the fact it's not identified -- I can't quite see you.

Q. I can't do it both for them and you.

A. We're friendly, and I like to look at you.

MR. REILLY: Can everybody see that?

A JUROR: Yes.

THE WITNESS: It's true.

A. Anyway, within limitation, it is not identified. It is a keratin. He should have said which keratin. If he got a positive, he should have tested for high molecular weight and for CK-7. He didn't. I see a positive keratin. It's typical lung cancer, not kidney cancer.

Q. You put that --

A. Please understand within the limitation of the fact it's not properly identified. Let's say it's really a high molecular -- sorry.

Q. Why don't I write down "Not properly identified"?

A. Okay. But if it was a high molecular weight keratin, it is

stronger evidence it is in favor of lung cancer and against kidney cancer. If he is talking about CK-7, it's evidence for lung cancer.

Within the limitation, it looks like evidence for lung cancer.

Q. Okay.

He had a positive EMA. Correct?

A. Yes.

Q. That is, in your interpretation, indicative of lung cancer or kidney cancer?

A. Well, based on the reported findings, I mean, it's not just my interpretation. I know EMA or epithelial membrane is almost always positive for lung cancer. In patients that have the kind of renal cell cancer that was contemplated in this case, meaning clear cell renal cell carcinoma, there are three major types of renal cell carcinoma, but of the clear cell there is

one particular type of clear cell which is called granular clear cell. Nobody suggested that in this case. If it is a granular clear cell, twenty-one percent of them are positive for EMA. If it is not a granular clear cell it is much less. It is close to zero.

So, without stating whether this was a granular clear cell -- and it isn't. Nobody suggested it is -- but without stating that it was a granular clear cell renal cell carcinoma, I would say a positive EMA is strong evidence in favor of lung

cancer and strong evidence against kidney cancer, but in fairness, if it had been a granular clear cell renal cell carcinoma, which nobody said it was, then twenty-one percent are positive for EMA.

So, it is one hundred percent for lung, twenty-one percent for granular clear cell renal cell carcinoma.

For me, that's evidence against kidney cancer and for lung cancer.

Q. If Dr. Nadji comes here and says "No, no. I never was suspecting, nor was anybody else suspecting this was a granular clear cell carcinoma," then it is strong evidence against renal cell carcinoma?

A. Sure, and particularly given the fact -- first of all, almost one hundred percent or one hundred percent of lung cancers are EMA positives, and also given the fact the only kind of renal cell carcinomas that are typical positive for EMA don't metastasize. That is called a chromophobe renal cell carcinoma. So, weighing it all together, I would say if the EMA is positive, you should say this is probably not a renal cell carcinoma, unless you want to bet on the two out of ten, but only if it is granular clear cell.

Q. I will put two out of ten.

A. For GCRCC, that's what it is called, granular clear renal cell carcinoma.

Q. PSA. Any significance here?

A. PSA is prostatic specific antigen and the prostate metastasizes to bone and lung just like the kidney metastasizes to bone and lung.

Just like this is not a prostate cancer, this is not a kidney cancer. I am not surprised the PSA was negative. I didn't think the patient had prostate cancer, but it doesn't have an indication for kidney versus lung. It is not prostate cancer.

Q. Can I put down here "inapplicable" on the issue of whether this was a renal cell carcinoma?

A. I agree, it doesn't have any impact on renal versus kidney, but it is a good example of how it's not prostate, even though prostate typically goes to bone, and it's not kidney.

Q. CEA. He had a negative. He reported a negative CEA. Correct?

A. He did report that. It turns out the CEA is positive in this case, but he did report the CEA was negative.

Q. And you believed the CEA was actually positive because you looked at the slide?

A. Not a question of whether I believed it or not. I saw it with my own eyes. I saw it was positive without question.

I looked at the slides and they were definite, definite CA positivity. I am talking about the slides from Dr. Hammar.

I didn't actually see the glass slides. I saw the

photomicrographs. The CEA was positive. It is not positive

like the CK-7 is in this case. The positive CK-7 in this case excludes renal cell carcinoma. You cannot have a markedly three plus four plus CK-7 in a renal cell carcinoma. To my knowledge, that has never ever been reported.

So, the positive CK-7 just blows out the renal cell carcinoma, but the CEA, you can have a negative CEA in lung cancer. It's usually positive. That's usually positive. It was done in this case and it was actually negative, so you can have about twenty percent or less CEA negative. CEA is normally negative in a renal cell carcinoma. So, it is negative negative in this case.

Q. Doctor, I just want to know did you look at Dr. Nadji's CEA slide?

A. Not the slides. I saw only the report.

Q. When you said earlier it was actually positive, you are not saying you looked at Dr. Nadji's slide?

A. And he read it wrong. I didn't say that. You are right.

Q. All right.

If his slide is actually negative, is that an indication of renal cell carcinoma or not?

A. It's not. It is simply -- it's a negative. So, it is useful. You asked -- somebody asked me in deposition.

Q. I am going to change this. I wrote down that you said his CEA was negative. You are saying you did not look at his CEA?

A. His CEA was reported to be negative. I believe him. He said it was negative. I think that does not support lung cancer, and --

Q. It does not support renal cancer?

A. Does not support lung cancer. A negative CEA does not support lung cancer and is what is observed in kidney cancer, but it is not a positive and, therefore, it doesn't tell you that's what the patient has.

It's just a negative. It's what you usually see. Positive value -- you asked me in deposition as to chemical stains are much more important as a negative.

Q. Actually, I didn't ask you any questions.

A. You are right.

Q. Just so I have got this straight, a negative CEA --

A. Yes.

Q. -- doesn't support lung cancer?

A. Correct.

Q. But it doesn't support renal cell carcinoma either?

A. It's what's seen in renal cell carcinoma. So, it is normally negative, but one shouldn't read too much into negative.

Q. Ikt does support renal cell carcinoma, although it is not of great significance to you?

A. I think that's fair. It's a negative. It isn't very helpful. It's what I would expect to find. But I would never

expect to find a CK-7 positive --

Q. I just want to focus on CEA.

A. No problem. I am saying to you I would expect it to be negative in kidney. I would expect it to be positive in lung.

Q. RCA. I have kind of run out of space here.

A. Renal cell carcinoma antigen.

Q. All right.

And Dr. Nadji got a negative RCA?

A. Correct.

Q. How do you interpret that?

A. It doesn't support kidney cancer.

I do not know in his hands what percentage is false

negative, but the absence of a positive does not support the diagnosis.

So that finding is against the diagnosis or nonsupportive of the diagnosis of kidney cancer. It is always a very specific antigen. If it had been positive, it would have helped. Its negativity doesn't make that much difference.

Q. Should I say it doesn't make that much difference?

A. Since it's such a specific antigen, it is negative finding is against the diagnosis of kidney cancer.

Q. Her-2/Neu?

A. Negative. This is evidence against kidney cancers. Thirty percent of kidney cancers are positive for Her-2/Neu.

This is an antigen more typically found positive in

breast cancer. In fact, it's a breast cancer test. Thirty percent are positive in renal cell carcinoma and, in fact, this antigen has been proposed as a vaccine antigen against kidney cancer.

So, the idea is to make a vaccine against Her-2/Neu to use it to prevent people from getting kidney cancer.

The fact that it's negative means that this cancer is either not a kidney cancer or it's one of the seventy percent that are negative, even though it is a kidney cancer.

If it had been positive, it wouldn't have proven kidney cancer, but it would have supported it. The fact it is negative is evidence against kidney cancer?

Q. So, I have written "Against kidney cancer".

A. Yes.

Q. All right.

The other topic I want to talk to you about is risk factors for the development of kidney cancer.

A. Very good.

Q. Is there an article that you rely on as being authoritative on this topic?

A. There are many articles, but I actually pulled out a few recent, very recently published review articles that review thousands and thousands of patients since about 1966.

Q. I just need to know if there is a name.

A. Sure. Depends on which topic you want. Hypertension or

obesity or smoking? There are three main risk factors.

Q. I would like to talk to you for a minute --

A. Okay. Go.

Q. You said obesity is not a risk factor for men or --

A. I did not say that.

Q. What is correct?

A. I said many of the articles published on this topic -- and I will refer you to the review paper published by Bergstrom, B-e-r-g-s-t-r-o-m, published in the British Journal of Cancer in 2001, and this particular paper reviews thirty studies published between 1966 and 1998 on the question of obesity and kidney cancer.

First of all, it recognized, the paper recognized many of the papers have previously identified that the risk for renal cell carcinoma associated with obesity is only in women. Some of the papers say it is also in men. The paper, that is the Bergstrom paper, eventually provides the explanation.

The explanation is that in a society while the same number overall of men and women roughly are over ideal body weight, the percentage of women who are more obese is greater than men.

So that has had an epidemiologically incorrect impact. The reason is the relative risk for obesity is related to the

degree of obesity. If a person has slight obesity, the risk multiplier for renal cell carcinoma is slight. But they get to

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a certain threshold above which the relationship is much more intense. So, very obese people, whether they are male or female -- and females tend to be more obese than men -- very obese people have a greater, easier to detect effect. Now the effect is not huge. It is about 2.4 times.
Q. Is that for men?
A. No, that's for everybody who is extremely obese.
Q. What I would like to have is what is the risk factor for kidney cancer for men at, I think you said, 28.5?
A. It's one. There is no multiplier. For BMI under thirty, there is no increased risk. Body Mass Index under thirty, there is no increased risk.
Q. You don't treat kidney cancers, do you?
A. I sure do.
Q. All right.
A. In the sense I make the diagnosis. I deal with it. It's a big problem, but I am not the doctor who chooses the chemotherapy or sends the patient for surgery. But I see cases.
Q. What you have indicated is if a man has a Body Mass Index of 28.5, there is no increased risk for kidney cancer. Right?
A. Correct. The relative risk for kidney cancer is 1.0. For BMI of thirty --
Q. You have already told us you think the BMI in this gentleman is 28.5?

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A. Correct. I have calculated it at 28.5, and then I recalculated it at the highest stated weight in the medical record and the highest stated weight gave me still a BMI under thirty.
Q. Okay.
Doctor, you indicated seven out of ten kidney cancers are caused by smoking. Is that right?
A. It's somewhere between a seven and five out of ten. McLaughlin, in a very large study published in the Journal of the National Cancer Institute reported it was seven out of ten.
Q. Any particular kind of kidney cancer?
A. Clear cell renal cell carcinoma is the most counted. It counts for seventy to eighty percent. It hasn't been possible in the literature to identify the differences.
Q. Is there a different kind of cancer in the kidney called transitional cell?
A. That's not a kidney cancer.
Q. The transitional cell carcinoma is not the seven out of ten or five out of ten you are talking about?
A. Correct. I am talking about renal cell.
Q. If I put down here "Smoking for RCC not" -- is transitional cell carcinoma called TCC?
A. Yes. Transitional cell carcinoma is almost like a bladder carcinoma.
Q. Let me just finish it.

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A. Okay.
Q. "Smoking for renal cell carcinoma not transitional cell carcinoma."
It's seven out of ten cases are caused by, you say --
A. A few moments ago I said five to seven. Seven is -- you have to take five to seven. That is the variation in the report.
Q. I put it down "Five out of ten to seven out of ten" --

A. That's McLaughlin.
Q. -- "are caused" --
A. By cigarette smoking.
Q. But that is not transitional cell carcinoma. Right?
A. Correct. Transitional cell carcinoma is much less common. There are very few cases, and I don't know what the multiplier is from smoke, but it's more of a squamous cell carcinoma and I believe a lot of those cases are caused by smoking. Excuse me. Just because it's like a bladder cancer and the effect of smoking on bladder cancer is huge.
Q. The relative risk for RCC from smoking would be what, 6.5?
A. For smoking -- well, it depends on duration of smoking. The relative risk has been reported for more than forty-five years for men. It is 7.2.
Q. 7.2?
A. 7.2 exactly.
Q. Now, the final category I want to talk to you about is

hypertension.
A. Yes.
Q. Now, doctor, is hypertension a risk factor in men for the development of kidney cancer?
A. A little bit, yes. Not like obesity, but, yes.
Q. For men with a BMI of 28.5, there is no increased risk. Right?
A. Correct. But for men above a BMI of thirty, there is a small risk, and above thirty-five, there is a greater risk.
For hypertension, there is no such number. It is not like, you know, above a certain blood pressure there is a risk and below it there is no risk. The reason --
Q. Let me stop you right there.
So, there is a little elevation in risk. Right?
A. It's less than double. The best that could be determined is it is 1.7 for all people with a diagnosis of hypertension, whether they are treated or not.
Q. I have written "Relative risk 1.7," and you say that there is no calculation of a gradation based on the level of hypertension. Correct?
A. It hasn't been possible. I tell you it's 1.7 based on a review by Grossman. That's not Mr. Grossman, sitting over there. But it's by Grossman, published recently of all papers on this topic between 1966 and, I think, 2000.
The multiplier is less than two hundred percent. It's

about 1.7 for all hypertension. It hasn't been possible to create a blood pressure gradient effect.
MR. REILLY: No other questions, Your Honor. Thank you very much.
THE COURT: Mr. Cohen, redirect.
REDIRECT EXAMINATION
BY MR. COHEN:
Q. Doctor, I am not unmindful of the hour, but as you know, I represent Sylvia Allen and I have to ask you a few questions.
Let's go back to this other chart that Mr. Reilly did for a minute concerning the immunohistochemical staining.
He talked about with you concerning Dr. Nadji's reports and, virtually, went through Dr. Nadji's reports and repeated what was contained in Dr. Nadji's reports.
He talked with keratin EMA, keratin CHA, PSA, CEA, RCA and Her-2/Neu.
Is there another immunohistochemical staining that would be important and critical in the evaluation of the staining done to determine the type of cancer and the site of

the original cancer?
MR. REILLY: If you could write it on another page?
THE COURT: I was just about to say can you start on a fresh, clean page?
A. The answer is you bet.
Q. What is another one doctor. Is that mucincarmine?

A. Yes.
Q. What is mucincarmine?
A. Mucin, the mucincarmine tests for mucin.
Q. Mucin is what?
A. Mucus. It is present in globulets and cells that produce glands. Adenocarcinoma of the lung tries to produce crazy glands.
Q. If an immunohistochemical staining of certain biopsy or tissue is mucincarmine positive --
A. It's not kidney cancer.
Q. What is it?
A. It is probably lung cancer. It could be cancer of the ovaries, but this man doesn't have ovaries. But that's only one of them.
Q. Doctor, I want to show you a couple of things in addition to what we just did concerning the immunohistochemical staining and it pertains to a little bit about what Mr. Reid and Mr. Reilly were alluding to.
Let me show you, if I may, some of the Sylvester Cancer Center admission records of Bob Allen.
Do you remember when Mr. Reid talked to you and showed you on his board, it had yellow highlights excerpting out from Dr. Sridhar's entry in his records?
A. Yes.
Q. In your review of the records, doctor, did you notice a

report that was a consultation report in connection with Dr. Marco and his resident colleague Dr. Ossi?
A. I have that report right here.
Q. In that report in the record of the Sylvester Cancer Treatment Center, did Dr. Marco and Dr. Ossi, who were responsible for the radiation oncology treatment for Mr. Allen, feel that this is a lung primary?
A. Yes.
MR. REILLY: Maybe you could back that up so we could read it, if you don't mind, Your Honor? I just can't see it all.
THE COURT: All right.
MR. COHEN: I'm sorry.
BY MR. COHEN:
Q. Presently it is my understanding that it is felt that this is a lung primary and the patient has begun chemotherapy?
A. Correct.
Q. That was January 20th, 29th, 1999?
A. Yes, sir.
Q. Let's see what else Dr. Sridhar, his treating oncologist, also indicated in the Sylvester Cancer Treatment of Mr. Allen.
Are you familiar with records that look like this in the Department of Radiology order forms?
A. Yes.
Q. I want you to assume with me for purposes of this question,

doctor, that is Dr. Sridhar's signature. Okay?
A. Okay.
Q. 1/21 1999, top left. According to Dr. Sridhar, what is the diagnosis?

A. Lung cancer. He was right.
Q. Well, March 1st, 1999. According to Dr. Sridhar, what was the diagnosis?
A. Lung cancer.
Q. May 28th, 1999, what was Dr. Sridhar's diagnosis?
A. Lung cancer.
Q. We are now into July, 1999. What is Dr. Sridhar's diagnosis?
A. Lung cancer.
Q. August, 1999, what is Dr. Sridhar's diagnosis?
A. Lung cancer.
Q. Let me show you -- and I can show you more of those and I want you to assume there is more -- let me show you, if I could, the full report Mr. Reid showed you concerning Dr. Sridhar's discharge summary. Okay?
A. Yes.
Q. Now, what Mr. Reid showed you in a blowup was this section -- correct -- under "History"?
A. Right. Right, right, right. Correct.
Q. This is that same discharge summary?
A. Correct.

Q. Doctor, let me show you the second page, and tell the ladies and gentlemen of the jury, if you would, who dictated this discharge summary?
A. Cecilia Watson for Dr. Sridhar.
Q. Doctor, I just have a few more questions.
Doctor, let's see what we learned from Mr. Reid's cross-examination of you.
You came from Canada?
A. I did.
Q. You immigrated?
A. Yes.
Q. You came to live the American dream?
A. I absolutely did. I ended up leading a better life.
Q. Your family was proud of you, we learned?
A. My parents were here today. They were the lovely lady and gentleman sitting in the back of the courtroom.
They are tougher than they look.
Q. Your colleagues are proud of you?
A. A lot of them are, I guess. I mean, they have elected me to multiple things.
Q. We have learned in this cross-examination of you that you have done medical/legal writing. Correct?
A. I have.
Q. You have been involved in asbestos litigation. Correct?
A. For twenty years.

Q. By the way, is this an asbestos case?
A. It has nothing to do with it.
Q. Is this a lung cancer case?
A. Yes, sir.
Q. We learned that you have given a number of depositions in the past. Correct?
A. Hundreds.
Q. By the way, is Mr. Woodrow Wilner, is he sitting at this table?
A. No, sir. He has nothing to do with this case.
Q. He has nothing to do with this case?
A. Nothing.
Q. Now, does your medical/legal writing, does your depositions you have given in the past, does your prior experience in asbestos litigation, does that change the principles of

internal medicine?
A. No, and I stick to those principles always.
Q. Does it change the principles of pulmonary medicine?
A. Absolutely not. It's based on those principles.
Q. Does it change what the CT scans reveal and reflect in this case as to Bob Allen's lung cancer?
A. Not one bit.
Q. Does it change the immunohistochemical staining and the opinions of Bob Allen's treating physicians?
A. No, sir.

MR. COHEN: Thank you.
THE COURT: Thank you, doctor. You can step down.
[The witness was excused].
THE COURT: All right, ladies and gentlemen. We appreciate very much your patience. We are sorry we ran later than we have been running. We wanted to finish with this witness.
We will see you tomorrow 9:00.
9:00 is convenient, Mr. Yaffa, for your next witness?
MR. YAFFA: Yes, sir.
THE COURT: 9:00 tomorrow morning.
Please remember the instruction not to discuss the case with anyone or permit anyone to talk to you about the case. If there should be anything on the radio, television, newspapers, don't read it, watch it or listen to it.
Thank you very much.
9:00 tomorrow morning.
[The jury leaves the courtroom at 5:48 p.m.]
THE COURT: All right, gentlemen. Everybody that wants to remain and listen to this scintillating argument is welcome. If not, this is the time to leave. Otherwise, have a seat.
Mr. Reilly, you indicated -- we can do this in the morning if it has been a long day. Whatever is easiest and best for you.

I turned that down.
MR. REILLY: For the booming voice of Mr. Cohen.
THE COURT: Yes. Let's try that.
MR. REILLY: Judge, can you hear me?
THE COURT: The volume control, it's a brand new system and I don't know how to work it. I know how to turn it down. I don't know how to get it up.
MR. REILLY: I am happy to take this up tomorrow, say, at 8:30. Would that be at the Court's convenience?
THE COURT: Whatever you all want to do. Barbara is helping us. She has only been here a half a day. We start in the morning early and we go all day with one reporter. It is my staff I am more concerned with.
How long do you think the discussion will take?
MR. REILLY: I wouldn't imagine it would take more than a half-hour, for sure.
THE COURT: All right.
Mr. Grossman, what is your preference, or what is your schedule? You are the one who has to arrange the scheduling on the plaintiff's side of the case. So, you may have witness problems. I don't know. You alluded earlier to a scheduling, a possible scheduling problem.
MR. GROSSMAN: After you alluded to the possible scheduling problem which dealt with us calling Dr. Nadji tomorrow, Mr. Reilly graciously said "No, go ahead and call

him."
He then told me, or he then asked me if we had been in touch with Dr. Nadji, and I told him "Yes," we have been in touch with Dr. Nadji.
He then said "I have to object to your calling Dr. Nadji."
MR. REILLY: No, we have skipped one more factor. I wouldn't care -- maybe we better take it up now, Your Honor.
MR. GROSSMAN: I would like to take it up now.
THE COURT: I have no problem with it.
First of all, somebody give me a motion, so I know what you are talking about.
MR. REILLY: Well, I guess my motion is either to strike Dr. Nadji or strike him in part, but I am not sure how you can strike him or limit him because I haven't spoken to him, because I can't, and I don't know what his thoughts are.
Let me explain to you what the situation is, Your Honor.
THE COURT: First of all, let's start with I know Dr. Nadji has written reports. I have no idea who he is. Somebody has got to give me some background.
MR. REILLY: I will start from the beginning, which is usually a good place to start.
Dr. Nadji is the treating pathologist who performed the immunohistochemical staining that we have been talking

about in this case in January of 1999.
Dr. Nadji performed certain stains, interpreted them and wrote a report, which we have all been discussing now for some days.
THE COURT: He is the treating -- and you said a word.
MR. REILLY: Pathologist.
THE COURT: -- pathologist. Thank you.
Okay. The rest of it I understood. He did the staining tests that we have been hearing about.
MR. REILLY: Right.
And as I think you may know, plaintiff's counsel in their preparation for this case hired another expert, another pathologist, a Dr. Hammar, from out in Seattle, Washington.
Dr. Hammar took tissue and performed his own stains, more stains, different stains than Dr. Nadji performed. I forget the exact number, but as a round number, let's say he did an additional ten stains.
Now today, plaintiff's counsel indicated that they intended to call Dr. Nadji to the stand tomorrow. Plaintiff's provided us with an expert witness list. I don't have the date on it, but it was in keeping with the Court's Order.
THE COURT: I have been using it to get the spellings. I have it here. I have both of your lists here of all of the witnesses. I keep striking them all, with my thought being at some point we will get through the list.

Unfortunately there is no date on this. It is a pleading that has been filed or that I asked Ms. Kramerman to give me, lists of the witnesses. I have it here and I don't know the date either. I am sure it's in the file somewhere.
MR. REILLY: I am told the date is January 10th.
THE COURT: Okay.
MR. REILLY: So, on this list are experts listed and then there is a catch-all somewhere.
THE COURT: Rebuttal experts.
MR. REILLY: Well, no. Paragraph number 27 --
THE COURT: Okay.

MR. REILLY: -- in which the plaintiffs indicate "Any and all healthcare providers who rendered care and treatment and/or testing to James Robert Allen, including but not limited to," and among other categories is pathologists. Okay?

But what I asked Mr. Grossman, when I learned Dr. Nadji was coming, what I asked Mr. Grossman was "Have you shown him the slides that were prepared by Dr. Hammar?" and I was told that "Yes," they have shown Dr. Nadji the slides that were prepared by their hired expert.

Now that, if Dr. Nadji were to come here and testify regarding his interpretation of Dr. Hammar's slides --

THE COURT: Clarify one thing for me.

MR. REILLY: Yes, sir.

THE COURT: I am searching for Dr. Nadji's name.

MR. REILLY: It's not there.

THE COURT: How can they -- is your objection they can't call him at all?

MR. REILLY: You know what? I want to be abundantly fair. They said they would call the treating doctor. Dr. Nadji is what I would characterize as being a treating doctor. I didn't have a problem with that. But once you have shown him materials that were outside of what he did as a treater, then he is no longer coming here as a treater. He is coming here as an expert, a hired -- I mean, they may not be paying him, but they have altered his status. They have made him the kind of expert that should have been listed so that we could depose him and see what he had to say.

Now, have I spoken to Dr. Nadji? Of course not. I am not permitted under Florida law to do that. But I certainly object strenuously to Dr. Nadji coming here and expressing opinions about a combination of his work and the work of the hired expert of the plaintiff in this case.

THE COURT: Is Dr. Hammar -- I see him listed.

MR. REILLY: He is coming Thursday.

THE COURT: He is going to testify?

MR. REILLY: He is going to testify.

THE COURT: Or as far as you know.

MR. REILLY: There is no doubt Dr. Hammar is coming

here to testify.

THE COURT: So, your concern is that Dr. Nadji is -- is it the sequencing here, that he will testify before Dr. Hammar?

MR. REILLY: No, it is the fact he is now going to testify, not as a treating doctor.

His status has changed. When they gave Dr. Nadji the slides that were prepared by Dr. Hammar or his report, either one -- I don't know whether they showed him the slides or the report or both -- but once you inject into Dr. Nadji information that is well beyond what he gathered as a treating doctor, then he is no longer a treating doctor. He is now this hybrid of a treating doctor and somebody who has information from a hired expert, and it is unfair at this hour, halfway through this trial, to now present this person, put him on the stand and ask him questions about the work he did and the work that he reviewed that was performed by the hired expert by plaintiff in this case.

That's not fair.

THE COURT: Now, the Dr. Hammar's work was done in January of 1999?

MR. REILLY: No. Dr. Nadji's work was done in January

of 1999. Dr. Hammar's work was done three or four months ago.
THE COURT: Well, then, I'm sorry. I think you may have misspoken because I don't know when he did the work and I

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was trying to get the timing, and I wrote it down January of '99, but that was not Hammar. That would be Dr. Nadji's work was done in January of 1999?
MR. REILLY: Correct. Dr. Hammar's work.
THE COURT: I am like you. Let me write it down. Nadji was January, the 9th. Dr. Hammar did his work in --
MR. REILLY: 2002.
THE COURT: Approximately when?
MR. REILLY: Probably August, and it was done strictly for litigation.
THE COURT: I understand. You say you have not talked to Dr. Nadji because he was a treating doctor?
MR. REILLY: Correct.
THE COURT: Boy, I will tell you, I am really out of touch with the Florida rules. Why can't you talk to a treating doctor?
MR. REILLY: It is against the law here in sunny Florida, Your Honor.
THE COURT: I'm sorry?
MR. REILLY: It's against the law. Plaintiff's counsel can, with an authorization, but I can't --
THE COURT: He can't give you information without the patient's consent. Is that the bar to it?
MR. REILLY: Correct.
THE COURT: Then I haven't lost my mind. There is

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nothing to prevent you from subpoenaing him or attempting to talk to him. If they don't want to talk, you can't force him.
MR. REILLY: Correct.
THE COURT: I thought there was a new rule, if you happen to represent the defense, you can't talk to a plaintiff's treating doctor. I thought that's crazy, if they will talk to you.
MR. REILLY: You can't without an authorization.
THE COURT: I am not presuming all doctors know not to do it.
MR. REILLY: Here is the thing, Your Honor: If I had deposed Dr. Nadji during the period when discovery was permissible, I believe Dr. Nadji was not contacted by plaintiffs during that time frame. I don't know that, but that's my bet. My bet is Dr. Nadji was contacted by plaintiff's counsel very recently, and this Dr. Hammar information was provided to him very recently.
THE COURT: Nadji is the treating doctor and Hammar -- unfortunately, once I get them the other way around -- Hammar is the --
MR. REILLY: Hired expert.
THE COURT: -- the expert that did this staining testing, and you have taken -- you are not precluded from taking Dr. Hammar's deposition.
MR. REILLY: I took Dr. Hammar's deposition.

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THE COURT: Your concern is you couldn't have taken Nadji's deposition without consent and so you couldn't have taken it at any time.
Then what is your concern about him coming in now and testifying about something that you don't know about because you couldn't have learned it anyway? You couldn't take his deposition anyway.

MR. REILLY: Dr. Nadji was never disclosed as an expert who was going to testify regarding the work performed by Dr. Hammar.
THE COURT: Yes.
MR. REILLY: That's where the rub comes, Your Honor. If Dr. Nadji had not been shown anything connected with Dr. Hammar, I wouldn't have a complaint.
THE COURT: We are back to, again -- and you all are just very fond on both sides of putting all these people in boxes, labeling them, heart specialist, carpenters, experts, lay, fact witnesses. I read all these things that you all filed, all of you, and you carefully labeled them, all these labels.
Now, your concern is the treating doctor, Dr. Nadji, has been shown or may have been shown -- we don't know that yet, or maybe you do know, maybe you have been told by Mr. Grossman, that he has been shown these tests that the expert did.

Now, why is it he could not refer to that in giving his opinion about whether it's lung cancer or kidney cancer? I guess that's what we are getting to here.
If they had done all this way back when discovery was wide open and you all could take whatever discovery you wanted to, you couldn't have -- I understand you couldn't have gotten Nadji's testimony anyway.
MR. REILLY: I could have then. If they had disclosed Dr. Nadji as an expert witness who had reviewed things like Dr. Hammar's work, then I could have deposed him. I could have found out what he was going to say. I could have found out how Dr. Hammar's work influenced him, if at all.
But to spring this --
THE COURT: By the time Dr. Hammar did his work, Mr. Allen had passed away, had he not?
MR. REILLY: Oh, years earlier.
Dr. Hammar didn't get involved until 2002.
THE COURT: So, what Dr. Hammar would have told Dr. Nadji would not have affected Dr. Nadji's care and treatment of Mr. Allen.
MR. REILLY: True.
THE COURT: Could not have in any sense of the word, logically, because Mr. Allen had passed away, was dead.
MR. REILLY: True.
THE COURT: So, you apprehend or anticipate that

questions are going to be propounded to Dr. Nadji about his opinion about Dr. Hammar's work performed years after Dr. Nadji completed his treatment of the deceased?
MR. REILLY: Correct.
THE COURT: I think I understand your problem.
Mr. Grossman has been over there like a caged lion or something. Maybe he is going to tell me you are not going to ask him that question. I don't know why he is anxious to get up, but he is restless and hasn't had a chance to talk much today, and it's late in the day.
Mr. Grossman.
MR. GROSSMAN: It is not easy for me to have a lawyer of Mr. Reilly's ability not correct you gently when he leaves the impression that Dr. Nadji's deposition could not be taken.
He doesn't need our permission to take Dr. Nadji's testimony. Not at any point in time did he need Sylvia Allen's permission, Grossman and Roth's permission or the Court's permission to take the deposition of Dr. Nadji.

In fact, they had so much confidence that they were going to use Dr. Nadji that they listed him as a witness on their witness list, as did R.J. Reynolds. Both parties listed Dr. Nadji.

Now, Judge King, a pathologist probably never has face-to-face contact with a patient. What a pathologist does and what Dr. Nadji did in this case -- you heard Dr. Temple

testify to it today -- is he stands by in a room called the frozen section room, and as specimens are removed from the body of a living patient, in this case Mr. Allen, they are taken in, just imagine, dry ice, into that room, cytology, and the first thing Dr. Nadji would do -- and he is not an expert at this time and Mr. Allen is not a plaintiff -- is he takes a material and he looks at it under the microscope to determine that it could be diagnosed. That is, that enough material was furnished to him. Just like on this microphone, he tells Tom Temple, "Okay. You can close. You can close the patient. Finish up. I have got enough."

Then he fixes -- first he looks at the frozen section, makes an immediate diagnosis. Then he takes other portions of the material and he puts it in paraffin block, like wax.

Later on its available from that block to be cut down and they have taken the blocks, I presume, in the preparation of this case -- I cannot imagine they haven't. I cannot imagine that, especially since this issue is is it renal or lung has been raised. I would find this utterly fascinating if those were not the case. Those slides are then left at Jackson Memorial Hospital for the world to take by subpoena and use them and send them around as they see fit.

Now, when they listed Dr. Nadji as a witness, they were, obviously, captured by the fact in his early reporting he was raising some question as to whether or not Bob Allen, this

patient who he never saw, but whose specimens he read, whether or not the tissue material that came from his foot was an example of a lung cancer that traveled to the foot or a kidney cancer that traveled to the foot, renal cancer.

So, from opening statement on, they had been saying, and through all this cross-examination, "We know the truth," which is, of course, what this trial is all about, I think.

THE COURT: I am doing my best to make it that way.

MR. GROSSMAN: I think so.

THE COURT: I do have some serious problems when one, when two lawyers, both of whom I respect and want to believe and do believe, tell me diametrically opposed statements like, for example, that Dr. Nadji's deposition could have been taken and everybody would know exactly what he is going to say.

Once side says it can be, or it could have been. One side says it couldn't have been. Obviously, I am going to have to look at whatever case law or rules you have on this proposition before I decide this issue.

But, yes, we are in a search for the truth here and I think it is being very thoroughly, very thoroughly litigated and presented by both sides.

Now, where are we here? You are saying Dr. Nadji had the material. He was right there when the operation was performed by Dr. Thomas, I guess.

MR. GROSSMAN: Temple.

THE COURT: Dr. Temple. Thank you.

So, he made his diagnosis there, and he put whatever his diagnosis was in a report, and we have probably seen it a

half dozen times, and now you say -- how is this part or does it come up? How does it come up and does it come up, the problem that Mr. Reilly is objecting to, that is to say is somebody going to hand Dr. Nadji, do you propose, hand Dr. Nadji some of these slides and say "What do you think about them?"

How is this going to come up?

MR. GROSSMAN: That is the best question of all.

In the preparation of this case -- and I suppose all the lawyers look tired enough for you to know this has been exhaustively prepared -- back in May of last year, on May 24th, two people from my law firm went and met with Dr. Nadji. We met with Dr. Nadji, which we, of course, are permitted to do. We had a conference with Dr. Nadji. Dr. Nadji was extremely helpful to us and Dr. Nadji was also good enough to suggest that we do some further staining and studies, which we carried out pursuant to his request.

Now, of course, had his deposition been taken during the discovery period in May, June, July, August, September, October, November, December, any time, and I don't know what to say to you, Judge, but I just as soon turn in my license if they couldn't take his deposition. That's how strongly I feel

about it, and that that statement would go uncorrected when we adjourn just blows my mind.

MR. REILLY: Your Honor, that is not what I said, and I will make it so clear, and I am surprised Mr. Grossman is saying that.

Of course, we could have taken his deposition. What I said was we could not now. I made an assumption, but now I am going to make it even more. This is really quite a remarkable statement by Mr. Grossman, because when we deposed Dr. Hammar we asked Dr. Hammar "did you create these new slides, these new stains at the direction of counsel?" and he said "No, no. I created these slides on my own, without talking to counsel."

But now we have --

MR. GROSSMAN: That's --

THE COURT, gentlemen just a moment now. Just a moment now.

Can somebody get rid of that blasted billboard? I can't see the lawyers. You didn't have to move it. I could have gotten the Marshal. I need to have eye contact with folks.

MR. REILLY: (Complied.)

THE COURT: Now, you see, in absolute fairness to Mr. Reilly, I clearly understood the representation to be made that Florida law prohibited, prohibited the defense from taking

Dr. Nadji's deposition --

MR. REILLY: No, Your Honor.

THE COURT: Just a moment.

MR. REILLY: All right.

THE COURT: -- or statement, or going to talk to him, and I said "Gosh, things have changed since I was a State Circuit Judge," and that doesn't surprise me.

There are new rules all the time, but I wasn't familiar with that, and you said "Well, without consent," and then, of course, I picked up and said "Well, now, that makes sense, that you would probably have to get the patient or the patient's estate or the patient's widow's permission, or the doctor would."

Maybe he COULDN'T talk about confidential patient

matters, patient/doctor discussions, and all that, and we sort of, I thought, agreed that was the preclusion that you were talking about.

So, I was left with the firm impression that the defense lawyers were barred from taking, from talking to Dr. Nadji, the treating doctor, absent his consent or Mrs. Allen's consent, and that that is the reason that it wasn't done and that is the reason that this all came up, is coming up here at the last minute, or even in the middle of trial, because in my experience, whatever it was when I was a civil trial lawyer for ten, eleven years, and a Trial Judge for

the rest of the time, in civil litigation anybody can take the deposition of anybody else.

And if you are having difficulty getting the deposition of a doctor because a person who is in the category or status of a plaintiff, be it the administrator of the estate or a widow or whatever was refusing permission, it occurs to me it is the simple thing to go to the Court to get an Order authorizing it, which certainly would have been forthcoming unless there is some provision of the Florida Statute that absolutely bars it.

So, I am, was left with the distinct impression you simply didn't take Dr. Nadji because you couldn't, you were barred by law or rules of court.

Now, had you taken it, of course -- now I am told there is absolutely no bar to it. So, I have got an absolute 180 degree difference of opinion by two fine and experienced lawyers on what the law of Florida and the rules of court permit.

Now, we can take this several ways, and I am sure there is a practical solution to it in a moment.

If the deposition had been taken, Dr. Nadji would presumably have told you, if asked about this, asked the proper question about Dr. Hammar's involvement, he would have told you "I asked Dr. Hammar or I recommended to the lawyers," however it came up -- I mean, whatever is the truth -- he would

have told you, I am sure, and then you would have known how Dr. Hammar came to do the hired expert or expert testimony that he was requested to give.

Then, of course, you could have asked Dr. Nadji whether or not he reviewed any reports from Dr. Hammar, whether or not this had caused him to have any thoughts about his original diagnosis or later diagnosis, all those questions that one would ask to get his position tied down.

Then, of course, you knew that Dr. Hammar was hired or was, has done this testing because he is listed on all these witness lists.

Now, that's from one point of view and that is, well, by choosing not to take his testimony, if you could have, if you could have -- and maybe you will convince me with some rules of law that you are correct and you are barred by the law of Florida from doing that. You did refer to the law of Florida that prohibited it.

But if you could have, then this whole thing would not be a problem, other than if you are barred from taking it and you had no way of learning that Dr. Nadji recommended to the law firm for the plaintiff that they hire Dr. Hammar to do this testing and/or that Dr. Nadji had then reviewed a report, if he did, and I am working with logic -- he must have looked at something to cause this whole problem to come up here -- but read a report or whatever he did, then I don't know -- I mean,

you could have asked him all this. Either way, there is a practical solution to this problem, either way, whether there is a rule that precludes taking Nadji's deposition or there isn't. But aside from that, there is a way to resolve this in a practical matter.

I think we will do the least harm to both sides and keep it on a far and balanced playing field, but we will come to that as a last resort.

The other thing here is I don't know how this is going to come up, and you all are asking me to make about the twelve-thousandth anticipatory ruling. Both sides love to do this. I don't know how this is going to come up.

I presume Dr. Nadji will be on the stand and he will be asked something about these stain tests that were performed, apparently performed by Dr. Hammar, and he will say something.

Now, it all depends on what the question is and how he is asked the question as to whether or not it's relevant or not.

Simply labeling Nadji an expert or a lay witness, simply labeling Dr. Hammar expert or lay doesn't answer the question.

The labels have been a very sophisticated way of trying to fit people into categories upon which Appellate Courts have written cases from time to time where it developed in a trial that somebody was an expert or somebody was a lay

witness or, generally, those opinions as I have been studying them now on this preemption and these others things you have educated me on had to do with way before trial on motions for summary judgment and a lot of other things. A lot of these evidentiary things are determined how it comes up in the trial.

Now, how -- and I will ask Mr. Grossman and I will give Mr. Reilly an opportunity to tell me what he perceives or is concerned about -- how it's going to come up. If it differs from Mr. Grossman, would somebody, please, Mr. Grossman, tell me how in the world is this going to come up.

What is going to be asked of Dr. Nadji that focuses on this issue?

MR. GROSSMAN: Thank you.

Judge, I want to answer your question right now. He will say this merely confirms what he believed, I will represent to the Court, when we saw him back in May of 2000. He didn't need the staining. He simply said "If you wish to do it further, go ahead and stain it."

He didn't even send us to Dr. Hammar. That was Dr. Feingold who presented Dr. Hammar to us. He felt strongly then he would defend this case as a lung cancer case back in May.

THE COURT: The bottom line is you are going to ask Dr. Nadji at some point, or you would like to ask him at some point, after reviewing Dr. Hammar's report or after looking at

whatever he did --

MR. GROSSMAN: Yes.

THE COURT: -- whatever he did, talked to him or whatever he did, "Does this confirm your original diagnosis?"

That is what this is all about.

MR. GROSSMAN: You have totally understood it, along with this.

THE COURT: Mr. Reilly, what is there about that that would be any difficulty for the defense to cope with so easily and thoroughly as you have been doing on your

cross-examination? That's all he is talking about.
MR. REILLY: But it's extremely prejudicial, and it is not in keeping with the Federal rules of discovery and it is not in keeping with Your Honor's pretrial rules. It is completely prejudicial.
THE COURT: We can start from the top now. You say it is not in keeping with the rules of discovery. Now, why not? Why could you not have taken his deposition?
MR. REILLY: I could have taken his deposition. I never maintained I couldn't have taken his deposition. I said I can't talk to him. I can't talk to him under Florida law. I am not permitted to pick up the phone, call a treating doctor and say "Tell me, hey, what do you think about it?" and they can.
THE COURT: This trial has really gotten sophisticated

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with the use of words. All lawyers are using words with shades of meaning. What are you doing if you are talking to a doctor at a deposition and say "Doctor, give me your name." That's talking.
MR. REILLY: I said on the record.
THE COURT: I heard you. You left the distinctive impression Florida law precluded you from getting the information without consent, and I accepted that from you.
Let's move on. How does it violate my Order on giving you a year to do your discovery? How does it violate my Order?
MR. REILLY: Your Honor, just so I have made the record clear --
THE COURT: You better try to convince me and worry about the record less. I am trying very hard to understand your position. I really am.
You are saying it violated my rule permitting discovery. I would like to know how.
MR. REILLY: Your Honor, you required that both parties disclose its experts that they intended to call at the time of the trial of this case.
THE COURT: Yes.
MR. REILLY: You gave us a deadline for doing that.
THE COURT: Yes.
MR. REILLY: You ended discovery at a particular date. It ran out October or November of this last year.

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Dr. Nadji was never disclosed as an expert by plaintiff's counsel. He was encompassed under the catch-all phraseology of a treating doctor, which I have no problem with.
THE COURT: What is a treating medical doctor if he is listed as a witness? See, here again, we are getting into this sophisticated labeling that is troubling me a bit.
He is listed as a witness. You know they are going to call him. You know he is a treating doctor. You know that they are going to tender him as a medical doctor, presumably, and they are going to ask him medical questions that call for opinions.
You knew that he was going to say in his opinion Mr. Allen died of cancer caused by lung cancer or --
MR. REILLY: What I knew he was going to say is exactly what is in his records, Your Honor. He is the guy that says this is a renal cell carcinoma.
THE COURT: Again, we are getting these diametrically --
MR. REILLY: Give me --
THE COURT: Just a moment. I am getting these diametrically opposed submissions to the Court.

You are saying you believe Dr. Nadji was going to say it was not lung cancer, that it was kidney cancer. Mr. Grossman says that what Dr. Hammar did confirmed his diagnosis that it was lung cancer.

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Now, which one of you is right? Which one of you is correct?

MR. REILLY: Your Honor, I have now put --

THE COURT: Let Mr. Reilly answer.

Which one is correct?

MR. REILLY: I have now put on the easel a blowup of Dr. Nadji's report.

THE COURT: In which he takes the position that what?

MR. REILLY: He says --

THE COURT: It's a big long report.

MR. REILLY: "Consistent with renal cell carcinoma," makes no mention of lung cancer at all none.

THE COURT: Renal cell, is that kidney or lung?

MR. REILLY: Kidney.

THE COURT: You tell me and I accept it. I am not having any trouble with that. I am trying to find out where we are.

You tell me his original diagnosis was kidney cancer or the fancy words for it.

Now, then --

MR. REILLY: Let my take this a step further.

THE COURT: Mr. Grossman is telling me something one hundred percent at variance with that.

MR. REILLY: What he is telling you --

THE COURT: I want to make sure this isn't more

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sophisticated interpretation of the English language to mean something to one lawyer and something to another and back and forth. I want to get plainly to it right now.

As I told you before when I turned to the other side, it's a rough rule of thumb, but you are winning. You might wait for a moment. It's late in the day. You have a big frown there. Too bad. You guys have facial expressions that will taint this jury at some point, if we ever get to the jury.

I thought you said, Mr. Grossman -- maybe I misunderstood you -- I am misunderstanding you lawyers a lot because of all this sophisticated language or interpretation of words that you are using. Now, you told me that Dr. Nadji, the only question that dealt with this issue was at the end of the day looked at Dr. Hammar's report.

"Does that confirm what you believe?"

He is going to say "Yes, it did."

That was what you told me.

Mr. Reilly, if he is correct in what he is telling me, that Nadji's diagnosis was kidney cancer, then Mr. Reilly would not be on his feet objecting. You see, Mr. Reilly, you wouldn't be objecting because it confirms what your theory of your case is.

So, let me ask you, Mr. Grossman, what is it that Hammar did that you say confirms Nadji's diagnosis, which was, you told me, that it was lung cancer? How do we reconcile

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that? I would like to hear from you.

MR. GROSSMAN: Yes, sir.

The defense reads the words in red as a diagnosis and it's not. The defense reads the words "metastatic carcinoma consistent with a renal primary" as being renal carcinoma, as being conclusive, as renal being from the kidney.

It is not.
They ignore all of the other tests that this man had at his disposal, "this man," meaning this pathologist. They put their stock in trade in the words "consistent with" as if this was his differential -- excuse me -- as if this was his final diagnosis.
May I say the uncontroverted testimony in this case also is that the single largest cause of renal primary cancer, kidney cancer, known is smoke, anyway. But for whatever reason, they decided that that simply meant it was a renal cancer and that was the end of the story, and it wasn't the end of the story, and the way you find out is by doing what we did, which is you either confer with him or take his deposition and show him things.
His other colleagues in the department are the ones who raised all of these issues that Dr. Feingold went through on the red pad that this could be lung.
So, we met with him and he said "Now that I look at this case in toto, this is not a renal primary," and he

says "I didn't say that." He says this was consistent with that. It's consistent with several things.
THE COURT: So, his testimony is going to be when he testifies for either you or the defense Mr. Allen's problem stemmed from lung cancer.
MR. GROSSMAN: That's what he told us on --
THE COURT: All right.
Now, that is something apparently that was -- it must have been -- I say "apparently" -- it was unknown to Mr. Reilly, but Mr. Reilly would be objecting so much if he didn't anticipate that was coming, logic tells me that, but let's stick with what we do understand.
If that is what he is going to say, then the fact Hammar did the stain test that indicated or may have indicated that it was lung cancer that spread, and that all Nadji is going to say is "That confirms my original diagnosis," where does that play out in all of this?
Is this just more sophisticated word interpretation of all these documents? If Nadji is going to the bottom line tomorrow when he sits there or the next day, is going to say "I diagnosed him as having lung cancer and Hammar confirmed it," if that's what he is going to be saying, is going to say, how does that fare with you all wanting to call him as your witness for these other things we have talked about?
In other words, I am baffled here. The two of you are

so far apart on what Nadji's diagnosis was. What he is going to say? I just don't understand.
Mr. Reilly.
MR. REILLY: Your Honor, if you are a treating doctor, you have treated the patient, you have built up a body of knowledge based on the treatment you have provided to the patient.
Mr. Grossman disclosed Dr. Nadji as one of their witnesses in that capacity, as a treating doctor, to come in and talk about what he did for the patient.
What Mr. Grossman and his office have done -- and my bet is that it was done. You know what? I am just positive it was done -- well after discovery closed --
THE COURT: He said May, May 24th. You can ask the doctor on the stand tomorrow.
MR. REILLY: You bet.
What he says is they met with him in May. They

couldn't have shown him Dr. Hammar's work in May.
THE COURT: They said they didn't. They met with him to find out what his diagnosis was. He told him. They learned at that time he was going to be helpful to them. Why they didn't wait and mousetrap you, letting you call him and ask him that, I don't know.
I am getting a little bit concerned with, it seems to me what the defense is saying is that you have read his report

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and in his report, in Dr. Nadji's report you were led to believe that he was going to say that the cause was kidney, kidney cancer, and you were led to believe that because of this language here that you have highlighted in red, which I can't read from here, but "consistent with renal" --
MR. REILLY: Carcinoma.
THE COURT: -- "carcinoma," and you interpreted that, with your considerable expertise and research and knowledge about medicine and these witnesses, as being kidney. That was your interpretation. So, you didn't bother going to talk to him. You didn't bother to take his deposition. You relied on that, and you were going to, if he said "Well, no. It might have been lung or it might have been something else," then you were going to cross examine him on the report and try to convince the jury that it was kidney cancer.
Well, that's all very sophisticated and that's all well and good if it works and there is nothing wrong with doing it that way. It's not bad. There is nothing improper about that. You can take that risk, take that chance, not go talk to the man, not take his deposition, which you could have done, apparently could have done.
If any of you find anything to the contrary, I want you to let me know by tomorrow morning. But, here we go.
So, you say "All right," using my sophisticated interpretation of that language and the medical

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sophistication, the doctor has used it, you used it, the lawyers, both sides used it, we are going to rely on that and try to convince the Judge because we label him expert, that he can't now tell what his diagnosis was at the time he was treating Mr."Allen."
Well, I don't know why he can't tell whatever he is called, as long as it's known to everybody that he was a treating doctor, a medical doctor that performed some tests or did something here and had an continue.
Prudence would say you go ask him what his opinion was. If he couldn't tell you, you get permission from me to make him tell you if he was going to be used by the other side.
So, it seems to me a little bit, you know, suspect here because you listed him as your witness. You, obviously, thought he was going to say it was kidney that caused the problem.
Now it appears, or somewhere along the line you must have figured out, or did you not know until tonight that he was going to say that it was lung cancer?
MR. REILLY: I did not know until tonight, Your Honor, that he had been shown something, whether it was the report of Dr. Hammar or the slides or work of Dr. Hammar.
THE COURT: You are going to have to read my lips. If you read a case somewhere that said something about talking to an expert or doing something, read my lips, it's very easy. If

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you are just learning tonight that Dr. Nadji since day one was going to say that this was lung cancer and not kidney cancer,

if you are just learning that, obviously, you are entitled to find out, to talk to him. I can work out a practical way. You can have time.

If you have known this for months and just sat back and thought "Well, we have got him in his report there and my interpretation and my doctors and my experts and my interpretation is that puts him in a corner where he can't say lung cancer, he has got to say kidney cancer, then I am going to rely on that and not bother with him anymore," well, that may be a problem for you. That was your choice.

I don't know what to tell you beyond that. If all the man is going to say is "My opinion then was lung cancer. Dr. Hammar, I have read his report and I now feel that confirms it," and that is the only question we are worried about here, that's one thing.

If it is that you are just -- I just don't understand. I don't know why -- are you concerned -- let me think this thing through. Are you concerned his opinion has changed since he wrote the report because of something Dr. Hammar has written in his report that he has now read?

MR. REILLY: Absolutely, Your Honor.

THE COURT: You are worried about that?

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MR. REILLY: Absolutely.

THE COURT: Then tell me these things. Tell me what is on your mind. I can get to the bottom of them. I'm sorry, but all this sophistication about, "Well, you know, if they labeled him expert, we could have done thus or so."

All right then. They are worried. We are fleshing out what is the real concern.

MR. GROSSMAN: He has --

THE COURT: The concern has been represented to me -- I don't want to put words in anybody's mouth. You correct me if I am wrong -- but the representation has been made to the Court that the defense, the defendant tobacco companies and their lawyers are concerned that Dr. Nadji has changed his diagnosis to something that it was not at the time he wrote his report or at the time he was treating Mr. Allen, whether he wrote reports or didn't, whatever he was doing, and that has come about because of the reviewing of Dr. Hammar's expert opinion on this subject.

They are concerned this has all come about at a time when -- well, they are suggesting it is improper under the rules.

Now, where are we? What is the plaintiff's response to that contention? It is a serious contention.

MR. GROSSMAN: He has the -- Mr. Reilly has no idea what he is talking about.

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THE COURT: Well --

MR. GROSSMAN: He has no idea what he is talking about. It's embarrassing. We met with Dr. Nadji Friday, May 17th, 2002 to go over the pathology and the wording of his report.

As you say, take all the language and throw it out. We met with him. They could have met with him at a deposition and reviewed this. They put their whole defense, if you could believe this, in the motion with the words "consistent with" ruled out somehow lung cancer, which it did not, which it did not, and now they want you to defend the case.

This is wrong, respectfully. We have been prepared to call him. They listed him as a witness. They have now

abandoned that notion that he is not listed or he is not a medical doctor and, therefore, he is what he is, Judge King, but it is curious to me now the subsequent tests have come back and Mr. Reilly doesn't know what he is saying. He didn't get them until yesterday or the day before or last week or whenever it was that we sent it to him realizing after opening statement that they are completely misinterpreting and misrelying upon this case as not being a lung cancer case. We thought they had something much better than that. Now we began to realize it is Nadji this and Nadji that. That's a witness they never saw.

Had they taken his deposition, which they could have done, they would have realized what he was going to say, and in

no place does he say it is not lung cancer. He says "consistent with".

That is the best I can do, Judge, because we played within the rules.

THE COURT: What is he going to say if you call him without respect to Hammar at all, leaving that to the very end, when the punch line comes and you ask this man, Dr. Nadji, what his diagnosis or his opinion was? That is his medical treating doctor. I know of no rule that precludes him from giving his medical opinion on his treatment whether he has been labeled an expert or a carpenter or whatever. That has been true for one hundred years in this jurisdiction or more.

Is he going to say, bottom line, lung or kidney?

MR. GROSSMAN: He is going to say what he told us -- and I will paraphrase that -- while this is consistent with kidney or lung, when you look at the total clinical picture, that is, everything that Dr. Temple, his surgeon, told you, it is lung cancer, is his bottom line, and he would have said that in May, as he said it to us, sir, on Friday, May the 17th.

THE COURT: All right.

MR. REILLY: Your Honor, just so we are clear, what Mr. Grossman just told you on the record without being completely clear about it was after our opening statement, the plaintiff's counsel went to Dr. Nadji --

MR. YAFFA: No, we didn't.

MR. GROSSMAN: You are so wrong.

THE COURT: Pardon me. I want to hear from Mr. Reilly.

MR. REILLY: They couldn't have gone to him in May with a report of Dr. Hammar because Dr. Hammar didn't --

THE COURT: He didn't. Mr. Reilly, please, please. He didn't say that. He said they went and talked to him about his own report.

MR. REILLY: Your Honor --

THE COURT: He did not say that he went and showed him the Hammar report in May.

What he said was they talked to him in May, which he said you could have done. Anybody could have taken his deposition, and at that point in time he went on, but his diagnosis is going to be lung, not kidney.

MR. REILLY: Judge --

THE COURT: If you are telling me you just learned that tonight --

MR. REILLY: We are missing the real point here.

THE COURT: No, we are right on the real point here. That is whether or not this is a trial to find out exactly what happened, exactly what these people's opinions are or not.

I want to let you finish your submission, but don't take me off into a 2nd Circuit case that was on summary

judgment in a pre-pre-trial setting to tell me something

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labeled this or that.
What I am thinking is the doctor ought to take the stand. He ought to be subject to direct and cross-examination. He would give his diagnosis. We all agree he could do that.
At the end of all that, then you can cross examine him and say "Did you change your opinion? When did you change your opinion? Was it after you were shown the report? What is it?"
You can bring all that out and that is credibility and weight and you can blast away at it. But to say because they didn't label him expert you didn't bother to take his deposition or talk to him is not a reason to preclude him entirely, entirely, and that's what you are asking, I think, the Court to do.
I don't know how in the world we can get off on that. I think most evidentiary problems resolve themselves when we know what the questions are and what the objection is.
The objection here is letting him give an opinion or letting him say the words that "What I have learned from Dr. Hammar" -- and I still don't know how he learned it, when he did or what he did, but that can all be asked if it is relevant, but what he would be saying is "Dr. Hammar's report confirms what I thought at the time, and at the time I thought lung cancer."
That is what has been represented. If he says "At the

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time I thought kidney cancer and Dr. Hammar confirms it," you should walk away with smiles on your face. You have no objection.
I don't know how we get into these sophisticated word games we seem to be getting into. Isn't that where we are? The man testifies. He says what his diagnosis was at the time. He is asked whether or not Hammar's tests or report, has he read it. Yes, he has. When, or whatever.
"Does that change your opinion in any way?"
"No, it confirms it," and that's what is represented he is going to say.
You ask him "When did you read it? Wasn't your diagnosis kidney?"
You develop all that and hammer home he has changed his mind because he read a report from Hammar, Dr. Hammar, whatever his name is.
Barring anybody from going into those issues because somebody labeled him or didn't label him fact or expert, it seems to me is not relevant to the inquiry. I'm sorry. I don't know what else to tell you.
I think we throw the man wide open to thorough cross-examining. If it develops somebody persuaded him, as you have suggested here tonight, to change his opinion, then that is going to look very bad for him. It's going to look very bad for the plaintiff and you have scored a great point.

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If nobody persuaded him to change an opinion he had all along, except by the sophisticated wording that is in that report that these doctors all use and your interpretation that that meant kidney and his interpretation, if that is what it is, that he meant lung, then that gets flushed out, the jury gets to hear it, you all get to argue it and we all go home.
I don't know what else to do. I was going to say if this all comes as a shock to you, but I have to conclude it does not because you listed him as your witness.

MR. REILLY: I list many people as my witnesses, Your Honor, based on their records.
THE COURT: That makes sense. I understand. All right.
Well, I don't know how his report led you into any sort of unfair position. That's what -- if you can show me that, I will be glad to fashion some practical way to solve this. Maybe call him a day or two down the road or something of the sort, give you time to do something. I don't know. I want to be --
MR. REILLY: Let me follow you up on that one, Your Honor. Perhaps the thing to do is to allow us the opportunity to take his deposition and see what it is he is going to say. If they have shown him Dr. Hammar's report and this happened in the recent past, then we should be able to find out what influence that has had on him, how that has affected his

opinions.
THE COURT: They are going to ask him and he is going to say "It had no effect on my opinion."
MR. REILLY: That's not what's going to happen.
THE COURT: Here we go again. They tell me one thing. You are telling me another. You haven't talked to him. They have.
MR. REILLY: I don't know what effect anything is going to have. I didn't know until today, within three hours ago, he had even been contacted by plaintiff's counsel because, of course, I have no contact with Dr. Nadji.
THE COURT: Which is your own fault. I'm sorry.
MR. REILLY: Wait --
THE COURT: Just a moment.
This is going to be the end of this. You all could have taken his deposition. I am satisfied the law of Florida has not changed that dramatically since I used to be in State Circuit Court.
You could have found out precisely whether it was lungs or kidney from this man. If he wouldn't talk to you, if you say you are precluded from picking up the phone and calling him, I don't know, I don't know why you could not do that and say "Doctor, here is who I represent. Here is what it is. Will you talk to me?"
If he said "Well, yeah, sure, I will," or whatever, or

"No, I won't," well, then fine, but whether you can talk to him on the phone -- let me accept your statement, you cannot do that. You could have certainly taken his deposition.
So, sitting back and saying "We are going to rely on our interpretation. It is a valid interpretation," I understand how you got to that interpretation from reading this report, but that doesn't mean you don't find out, and if he is now going to say "I didn't mean lung," I mean, "I didn't mean kidney, I meant lung," he could have done that if nobody had ever talked to him. That could come up in a trial and it does. Unless you talk to people ahead of time and find out, you never know.
Mr. Reid, you have been over there very quiet for a while. You wanted to say something. You have had a lot of experience in these matters. How in the world can anybody be harmed or hurt if the witness testifies and he is asked all these embarrassing questions about "Did anybody try to persuade you otherwise?" or "Did you change your opinion?" and all that, and assuming if he says "Yes, I did change my opinion," then you have got an argument here to make.

If he says "No, my opinion has been consistent throughout. This simply confirmed it," then all of this is really over nothing.

MR. REID: What I was going to say, Your Honor, I was going to talk about the process. Of course, the discovery

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process is the subject of lots of rules and this Court's Order interpreting the rules and our concern was that while occasionally I know we talked about pigeon-holing and so forth, there is a very clear distinction between experts and fact witnesses. Experts, as we talked about several times, are very powerful because they are experts and the Court anoints them as experts in the eyes of the jury.

THE COURT: You only take expert depositions? You don't take fact depositions? Don't tell me that. I have seen you take thousands of them.

MR. REID: If I could just finish? I am talking too slow. You are thinking faster than I am talking.

What happens is when someone discloses an expert, the Court has a requirement, you have to give them opinions through a disclosure and you are allowed to take the deposition based on that and the point here was there was no disclosure.

THE COURT: Can't you do the same thing with a fact witness?

MR. REID: You can depose people, but the prejudice is, that I was going to point out, is where a witness has never been mentioned as an expert, meaning -- please -- not allowed to get into certain areas -- a treating doctor is a fact witness about his treatment. He is an expert about other things. We are now -- we have done opening statements. We put on witnesses.

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THE COURT: You always ask a treating doctor what his diagnosis is and he always tells you. 1,000 cases you have been in. When he says that, you know. He says lungs or kidney and you know what it is.

MR. REID: I believe we are prejudiced by a witness suddenly during trial, after we have had witnesses, we have cross-examined witnesses, we have had openings, suddenly having a witness declared as an expert and permitted to give opinion testimony beyond his treatment, that is the prejudice, I believe.

THE COURT: You would have anticipated that a treating doctor would come in and when he is finished telling what he did and all the steps he took that he wouldn't be asked his diagnosis?

MR. REID: No, sir.

THE COURT: Isn't that always done?

MR. REID: Yes, sir.

THE COURT: At the end of the day, Nadji would say "I feel that he died of kidney" -- you thought he was going to say kidney cancer. It turns out he is going to say lung cancer.

The plaintiffs found that out by going and talking to him. If he was labeled an expert, you say you could have taken his deposition.

MR. REID: We would have --

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THE COURT: If he was labeled a fact witness, you could take his deposition.

MR. REID: We would have had a disclosure if he had been an expert. We would have known about these other areas.

THE COURT: You are not answering the question.

MR. REID: Yes.
THE COURT: You would have found out what his diagnosis was and whether it was consistent with what your experts and you thought he meant by the words he used. You didn't do that.
So, asking me in the middle of the trial that everybody has done mind boggling work to get to this point in terms hundreds, thousands of hours on ya'll's part, stopping this trial is crazy.
Let me inquire. Is there -- and trying to lean way over backwards and not have this trial get derailed on semantics, which is what we are into here on my judgment -- can the doctor be able to take a deposition on his original diagnosis and whether or not he has changed his opinion since that time, whatever his answers are? Can that be arranged, given the doctor's schedule?
MR. GROSSMAN: I don't know. Dr. Thomas Temple, his colleague, same Jackson Memorial, same University of Miami professor, testified today and his deposition was never taken.
We have already done this.

THE COURT: We are going round and round.
MR. GROSSMAN: He was asked what's his bottom line. He said lung cancer. That is the military doctor, Judge, Thomas Temple, who is a surgeon.
We are allowed to ask doctors hypothetical questions. They just want to come in and read the language, "Thank you very much. Please leave." These are people that are subject to examination both on direct and cross. We have done it --
THE COURT: Is the plaintiff's counsel willing, if this can be arranged, to make Dr. Nadji available for a half-hour of deposition, question and answer about his diagnosis, whether it was kidney or lung and whether or not it was affected by anything that he read or learned about in Dr. Hammar's report? Are you willing to do that in an effort to lean over backwards?
MR. GROSSMAN: No, sir, not in the middle of the plaintiff's case. I have to see family tonight and we don't control him now.
THE COURT: Okay. That's fine. It is quite clear to me.
This man is one of the treating doctors. Clearly, he should not be barred from testifying totally or in part because it was the interpretation of counsel that he was not or was or was not, whatever your interpretation is, an expert.

Certainly, treating doctors have from time in memoriam been able to come in and tell what they did in treating a patient, get into medical terminology, get into an explanation of what it meant to give a shot of morphine or whatever it is. This is all in the realm of expert testimony. I don't have to label him an expert.
This seems to be critically important to everybody. I am not sure why, but he is going to come in. He will be able to come in, testify as to what he did and what his opinion was at the time as far as where this cancer came from. The same thing Dr. Thomas, I believe his name was --
MR. GROSSMAN: Thomas Temple.
THE COURT: -- Dr. Temple earlier testified, and he will be, he will tell us whatever he will tell us.
If he opines it is kidney cancer, so be it. If he says lung cancer, so be it.

Then the plaintiffs may inquire and ask him whether or not he has reviewed Dr. Hammar's report, or whatever it is he did, and did that change his opinion in any way, and he is going to answer, they say, "No, it did not."

He may say otherwise. He may say "Yes, it did."

If he did, at that point in time you will be able to literally crucify him in terms of whatever comes out on cross-examination on that.

If he says it simply confirmed it, then that's where

it was and defendants could have learned this by the simple matter of taking this man's deposition.

Balancing all this and placing, which I don't like to do -- I am very unhappy with having to do it -- but placing blame on who is at fault with the predicament we are in now, I have to conclude it tips toward the defense because they could have asked this man to confirm because they are sophisticated, medically sophisticated, because this is a medically sophisticated case, his understanding of what the reports meant.

You can cross-examine him until the cows come home what he meant by those words and try to show to the jury he is changing his opinion or diagnosis. That's all fair game and that's what cross-examination is all about.

So, the motion to preclude him in totality or in part is denied.

We will start tomorrow morning at 9:00.

C E R T I F I C A T E

I hereby certify that the foregoing is an accurate transcription of proceedings in the above-entitled matter.

_____ _____

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